University of Alberta

Borderline Personality Disorder: The Impact of Shame on Traumatic Feelings, Social Problem-Solving Ability, Social Support and Psychiatric Symptomatology

by

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Abstract

The main purpose of this research project was to collect self-report information examining the emotion of shame in women diagnosed with Borderline Personality Disorder (BPD). To better understand the impact of shame, the variables of psychiatric symptomatology, trauma, social problem-solving ability and social support were examined in a clinical group of female outpatients diagnosed with BPD (n = 36) and a control group of University women (n = 49). To address all the variables set out in this research design, the dissertation was organized into three papers. Paper 1 focused on the relationship between shame and psychiatric symptomatology. This examination revealed that shame was a prominent emotion felt by the BPD women and that higher levels of shame were significantly correlated with higher levels of psychiatric symptomatology. Paper 2 focused on the relationship between trauma, shame and psychiatric symptomatology. Those who reported the most difficulty coping with past trauma also reported the most shame. Interestingly, the type of trauma reported (e.g., sexual abuse or a non sexually violent trauma such as a serious car accident) was not related to the BPD woman's current level of psychiatric symptomatology. This finding was contrary to the common assertion that sexual abuse is a defining feature in the life history of the woman with BPD and has a more negative impact than other types of trauma. The goal of the third paper was to examine the relationship between shame, social problem-solving skills and social support. The BPD group is characterized as having chaotic and intense relationships. The findings from this study suggested that part of the difficulty for women with BPD is their use of an avoidance style of

social problem-solving. It appears that their tendency to ignore problems and attempts to have others solve problems for them, coupled with the negative behaviours associated with shame (e.g., attacking others) has a detrimental effect on their ability to sustain a positive social network. Further research investigating the effectiveness of different treatment methods on increasing problem-solving skills and/or reducing shame may enable a better understanding of how to alleviate some of this populations destructive behaviours.

Dedication

This dissertation is dedicated to my beloved late Grandfather, Howard Dobson (Papa Howie). Papa Howie was the type of man who others wanted to be with and be like. He had an infectious laugh, forgiving heart and a strong and courageous character. It is an honour to call a man like him my Grandfather.

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My most heartfelt acknowledgment is for my husband, Eugene Chan. He is a man whose actions speak louder than words and for this I am very grateful. Thank-you Eugene for all of the little things you do everyday. Lastly, I would like to thank our daughter, Emma, for being such a friendly, clever and beautiful baby girl who reminds us everyday what is truly important in life.

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CHAPTER 1

INTRODUCTION

Review of Borderline Personality Disorder

The Diagnostic and Statistical Manual of Mental Disorders (DSM) officially recognized Borderline Personality Disorder (BPD) as a diagnosis in 1980. The essential features of BPD are a "pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts" (American Psychiatric Association (APA), 2000, p. 706) (See Appendix A for the complete DSM-IV-TR criteria). It is considered a chronic, life-long disorder that is characterized by suffering to the self and others.

Maladaptive behaviours and emotional responses common to this population include poor boundaries, intense fears of abandonment, self-destructive acts (e.g., promiscuity and substance misuse) and impulsive anger. Further adding to the complexity of BPD are the rates of comorbidity with other Axis I disorders. Common co-occurring Axis I disorders are Mood Disorders, Substance-Related Disorders, Anxiety Disorders and Post Traumatic Stress Disorder (APA, 2000; Zanarini, Frankenburg, Dubo, Sickel, Trikha, Levin, & Reynolds, 1998).

While trauma is a commonly documented feature in the life history of women with BPD (Kroll, 1993; Linehan, 1993), it is generally considered a risk factor for the disorder rather than a causal mechanism. Other variables that have been examined by researchers as possible contributors to the development of the disorder tend to fall into two main camps, the biological/genetic theories and the psychological/social theories. The following section offers a review of the different theories as well as the theoretical position taken in this study.

Theories of Borderline Personality Disorder

The term 'borderline' developed out of a theory by Stern (1938) that there is a realm of psychopathology that lies on the border between neurosis and psychosis. Although, patients with BPD are now commonly believed to be closer to neurotic (i.e., anxiety disorders) than psychotic (i.e., schizophrenia), there are various theories about how this disorder is developed. While most theorists do not subscribe to the idea that there is only one cause of BPD, they do feel there are certain factors that put a person 'at risk' for developing the disorder. These risk factors are discussed under the umbrella headings of biological, social and psychological. A discussion of the theoretical viewpoint of this paper, the biosocial model of Linehan (1993) follows.

Biological Risk Factors

Biological theories, oftentimes called the medical model, begin with the premise that mental disorders are akin to physical disorders. For example, the DSM-IV-TR holds that, while mental disorders are not *actually* physical diseases they can be thought of as analogous to physical diseases. Thus, the treatment of choice within this model would be the use of prescription medication. Consistent with this view, research tends to focus on the role of the individual's biological functions, including such processes as the role of neurotransmitters and brain activity.

Many neurotransmitters have been studied, with the most common being norepinephrine (which is associated with behavioural activation), and serotonin (associated with behavioural inhibition). This approach has been used to try to explain the commonly found statistic that approximately 75% of the people diagnosed with BPD are female while 80% of those diagnosed with Antisocial Personality Disorder are male. One theory that attempts to explain this difference biologically is that the impulsivity common to both disorders results from underactivity of the serotonergic system and overactivity of the noradrenergic system (Paris, 1994). Other theorists have focused on examining brain activity using Positron-Emission Topography (PET) and have found reduced activity in the frontal and parietal lobes of BPD subjects. However, the samples tend to be very small because of the expensive and time-consuming nature of the research (Goyer, Andreason & Semple, 1991, as cited in Paris, 1994, p.37). While research in the biological area, especially genetics, is growing rapidly with scientific advances, there is "not yet sufficient evidence to fully justify this (purely biological) position" (Paris, 1994, p. 25). However, this area of research is very time consuming and may be too simplistic since there are multiple receptors and multiple systems associated with each neurotransmitter.

Other research methods used to study the biological influences on behaviour are family history studies and twin studies. The researchers try to answer the question of whether there is a biological vulnerability for BPD. Using family studies, Zanarini (1993) found that the relatives of individuals with BPD were more likely than controls to have other impulse spectrum disorders, substance abuse or

Cluster B diagnoses (especially male family members with Antisocial Personality Disorder). BPD is also said to "breed true" in that borderline individuals are five times more likely to have first-degree relatives with BPD than by chance alone (Zittle & Westen, 1998). The use of twin studies to gain information on the heritability of personality traits found the heritability correlation for monozygotic twins $r = .4$ to $r = .5$ for most traits. While a correlation of .5 is impressive in psychological research it also suggests that while biological factors may be necessary conditions, there are also other factors important in developing the disorder.

Social Risk Factors

Social risk factors act "by significantly lowering the threshold for psychopathology" (Paris, 1994, p.69). In other words, negative social factors are believed to influence an individual who is already susceptible to mental illness putting them at greater risk of both developing and maintaining the disorder. Social risk factors are usually examined using epidemiological research, for example looking at prevalence rates. One consistently reported finding is that those diagnosed with BPD are more likely to be found in lower socioeconomic groups and, as a whole, they obtain a lower than average level of educational achievement. To explain the higher proportion of individuals with BPD in lower socioeconomic classes, two theories are usually advanced. These theories, borrowed from schizophrenia research, are "social causation" and "drift". The former purports that the stress of poverty causes mental illness. The drift theory holds that because mental illness can devastate social and occupational functioning, individuals with mental illnesses, like BPD, migrate to society's lower echelons. Most evidence found using samples with schizophrenia points to the drift theory (Goodwin & Guze, 1989). However, the direction of causality with the BPD population is not clear.

Social disintegration is also cited as a risk factor, particularly in the sociology literature. Social disintegration consists of such things as a community with negative factors like weak leadership, broken homes, high crime, high migration and poverty.

Psychological Risk Factors

The psychological risk factors "are related to a variety of childhood experiences and fall into three general categories: trauma, early separation or loss, and abnormal parenting . . . although, trauma seems to be more specific to BPD" (Paris, 1994, p.43). Research by Paris, Zweig-Frank and Guzder (1994) examined the abuse histories of 78 women with BPD and compared them to 72 women with a personality disorder other than BPD. They found that that those patients with BPD and a history of childhood sexual abuse (CSA) had "a variety of experiences, some more or less traumatic" (p. 378). Only a subgroup of BPD women reported severe abuse and CSA had a low specificity to BPD. One possible explanation for the lack of specificity for CSA in BPD is that childhood experiences have a different impact depending on how they are processed by the individual (Rutter & Rutter, 1993). Other psychological risk factors include separation and loss, parental psychopathology, and lack of parental bonding. However, only trauma related to abuse remained a significant risk factor when multivariate approach was used (Zanarini, et al., 1998).

Linehan's Theory of Borderline Personality Disorder (Biosocial Theory)

Linehan's theory stemmed from her work with suicidal patients. She developed Dialectical Behaviour Therapy (DBT) as a comprehensive cognitive-behavioural treatment for complex, difficult-to-treat mental disorders. Originally developed as a treatment for chronically suicidal patients who met the criteria for BPD, the treatment has been modified through the years to address all the symptoms associated with the borderline diagnosis. DBT is based on a combined capability-deficit and motivational model of BPD which states that (1) people with BPD lack important interpersonal, self-regulation (including emotional regulation) and distress tolerance skills, and (2) personal and environmental factors often both block and/or inhibit the use of behavioural skills that clients do have, and reinforce dysfunctional behaviours. This cognitive-behavioural approach to treatment involves "identifying irrational beliefs, clarifying and facilitating the expression of those beliefs, and reinforcing healthy behaviours and choices made by the patient" (Kraus & Reynolds, 2001, pp. 346-347).

Research on the effectiveness of DBT is still in the relatively early stages, however the results seem promising. One study followed patients during treatment that lasted one year and a separate group of patients receiving therapies other than DBT. The DBT patients were less likely to drop out of therapy and less likely to make suicidal threats and gestures. DBT has also been demonstrated to reduce patients' anger levels and increase social competence (Linehan, Tutek, Heard &

Armstrong, 1994), reduce hospitalizations and health care costs (Swenson, Sanderson, Dulit & Linehan, 1994) and decrease self-harm and para-suicidal acts in institutional settings (Bohus, Haaf, Stiglmayr, Pohl, Böhme & Linehan, 2000; Low, Jones, Duggan, Power & McLeod, 2001). There also appears to be some benefits for the counselors who treat BPD including a decrease in burnout related to personal accomplishment (Little, 2000).

Linehan's theory on the criteria of BPD includes this applied work but also remains consistent with the criteria put forth in the DSM-IV. While Linehan has not redefined the criteria in the DSM-IV, she has reorganized the criteria somewhat (see Appendix B). Her reorganization was made to put emphasis on the DSM-IV-TR criteria that she found to be most intrusive and common to the borderline population and to group together criteria she found to be conceptually and behaviourally related. A comparison of Linehan's criteria for BPD with the DSM-IV criteria (Appendix A) and Zanarini, Gunderson, Frankenburg and Chauncey (1989) Diagnostic Interview for Borderlines - Revised (a popular instrument used in the diagnosis of BPD that is based on the DSM criteria) illustrates her adherence to the DSM-IV model.

Format of the Dissertation

The BPD population is often considered one of the most challenging and frustrating groups to work with. This frustration often lies in the inability of the mental health worker to obtain and sustain positive changes for the individuals diagnosed with BPD. The investigations that compose this research have focused on several behavioural (e.g., withdrawal and avoidance of problems) and emotional difficulties (e.g., traumatic feelings, shame) common to this population. Specifically, the role of shame and the response of the BPD to feelings of shame are given a great deal of consideration in this research.

There is a substantial amount of anecdotal support and theory purporting that shame is an important emotion to understand when working with individuals diagnosed with BPD (APA, 2000; Linehan, 1993). Different theorists have conflicting ideas about what emotion causes the most difficulty for BPD individuals, but recently researchers have found shame to be particularly relevant to this population (Brown, Levensky, & Linehan, 1997; Rizvi & Linehan, 2002). Some have gone as far as to suggest that shame is the core emotion in BPD (Langley, 1993). While it may be premature to state shame as the core emotion, many researchers have begun to question the role of shame in many of the BPD negative and self-defeating behaviours and thoughts.

It is the goal of this researcher to examine the role of shame in four important aspects of the BPD individual's life. The four areas are psychiatric symptomatology (level of functioning), current traumatic feelings, social problem-solving ability and level of social support. Each of these areas has been reported to be important to understanding the BPD individual (APA, 2000; Coffey, Leitenberg, Henning, Turner & Bennet, 1996; Douglass, 2000; Linehan, 1993). The current research will build on the existing literature as well as adding a new dimension by focusing on the role of internalized shame in these areas.

To address the various issues presented in this study, the dissertation is written in a paper format consisting of five chapters. In Chapter 1, a brief literature review of the theories of BPD and essential features of the disorder are presented as well as the purpose and goals of the study. Three empirical investigations were conducted to explore the impact of the aforementioned variables on both a group of women diagnosed with BPD and a University sample of women acting as a control group (see Appendixes C, D and E for the information letters and consent form used). Each of these three chapters is outlined below.

The first study, in Chapter 2, was conducted to assess the impact of the negative emotion of shame on the level of psychiatric symptomatology reported by the women. The term psychiatric symptomatology is used here to refer to level of functioning. A high score on measures of psychiatric symptomatology corresponds with a low level of effective day-to-day functioning. Symptom domains used to assess general psychiatric symptomatology include such measures as level of depression (e.g., loneliness, hopelessness), interpersonal sensitivity (e.g., feeling inferior to others) and somatization (e.g., vague physical symptoms). The rational for this paper are based on Linehan's theory of Emotional Dysregulation and Criteria 6 of the DSM-IV-TR (affective instability). Both of these sources view the borderline individual as having significant difficulties in modulating and controlling strong emotions. Recent research has suggested that shame may be at the core of many of the borderline individuals other negative behaviours and problems in day-to-day functioning (Langley, 1993; Linehan, 1993; Rizvi & Linehan, 2002). This chapter is intended to establish the importance of understanding shame and the negative psychiatric consequences that may result when this emotion is left untreated.

Chapter 3 will present an examination of the relationship between trauma, internalized shame and psychiatric symptomatology. The variable of trauma will include all types of traumatic events and will not focus specifically on sexual abuse. While it is recognised that sexual abuse is commonly reported within the borderline population (Kroll, 1993) it is argued that one traumatic event is not "more traumatic" than another. Rather, the effect of the trauma depends largely on how the individual responds to it. This paper challenges the assumption that sexual abuse is the most important defining feature in the life history of the BPD and crucial to consider in the diagnosis and treatment of the disorder. This chapter further highlights the severe negative reaction to traumatic events by the BPD women. Namely, the elevated sense of shame and lowered level of mental health resulting from their perception of the trauma is discussed.

The focus of Chapter 4 is the relationship between internalized shame, social problem-solving skills and social support. The basis of this paper rests with Linehan's theory, specifically, her discussion of Interpersonal Dysregulation, and the corresponding Criteria 2 from the DSM-IV-TR (re: a pattern of unstable and intense interpersonal relationships). As Linehan (1993) states "in (her) experience borderline individuals, more so than most, seem to do well when in stable, positive relationships and do poorly when not in such relationships" (p.11). The difficulty here is that the woman diagnosed with BPD is consistently unable to sustain and maintain a positive relationship due to a severe lack of effective social problem-solving. To further complicate this, research indicates that shame may further impede problem-solving (Rizvi & Linehan, 2002). This chapter was written primarily for those in the mental health profession working with patients diagnosed with BPD. This chapter examines both the behaviours and emotional responses (especially shame) expressed by the individual, as well as possible treatment techniques that may be utilized to alleviate these symptoms (see Appendixes F – M for sample items and whole instruments that were used in the three studies).

A summary of the findings from the previous chapters, contributions and limitations of the research as well as directions for future studies are presented in Chapter 5.

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CHAPTER 2

SHAME AND PSYCHIATRIC SYMPTOMATOLOGY IN WOMEN DIAGNOSED WITH BORDERLINE PERSONALITY DISORDER

Purpose

The purpose of this study is to examine the emotion of shame in the Borderline Personality Disorder (BPD) population. Specifically, the focus is on whether a higher level of shame is related to a higher level of psychiatric symptomatology in this population. There is a great deal of anecdotal support and theory emphasizing shame as an important emotion to understand when working with individuals diagnosed with BPD (e.g., American Psychiatric Association (APA), 2000; Linehan, 1993). While different theorists have conflicting ideas about what emotion causes the most difficulty for BPD individuals, recently researchers have found shame to be particularly relevant to this population (Brown, Levensky, & Linehan, 1997; Rizvi & Linehan, 2002). Some researchers even suggest that shame is the core emotion in BPD (Langley, 1993). While it may be premature to view shame as the core emotion, many researchers have begun to question the role of shame in many of the BPD individuals' negative and self-defeating behaviours and thoughts.

Review of the Literature

Borderline Personality Disorder (BPD) was officially recognized by the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a diagnosis in

1980. The essential features of BPD are a "pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts" (APA, 2000, p. 706). BPD is considered a chronic, life-long disorder, which is characterized by suffering to the self and others.

Common maladaptive behaviours and emotional responses frequently found in this population include poor boundaries, intense fears of abandonment and self-destructive acts (e.g., promiscuity and substance misuse). BPD occurs in approximately 10-11% of outpatient and 19-20% of psychiatric inpatient populations (APA, 2000; Berber, 1997). The prevalence of BPD in the general population is estimated at 1.8 - 3%, depending on the population studied (APA, 2000; Berber, 1997; Widiger & Weissman, 1991). Consistent across many studies is a considerable gender difference in the diagnosis of BPD. Approximately 75% of those diagnosed with BPD are female. The largest population diagnosed with BPD consists of women between 18 and 30 years of age (APA, 2000; Hubbard, Saathoff, Bernardo, & Barnett, 1995; Linehan, 1993).

Most researchers agree that the development of BPD includes both a biological susceptibility and environmental factors. Marsha Linehan (1993) developed a popular theory of BPD. This theory arose out of her work with chronically suicidal individuals. She also developed a comprehensive treatment plan for suicidal and parasuicidal women and found that her treatment was effective as well with the notoriously difficult to treat population of BPD.

Linehan (1993) hypothesizes that there is a biological risk factor in the development of BPD and she labels this factor as "emotional vulnerability". She defines emotional vulnerability as a propensity for being excessively sensitive to emotional input and having intense and protracted reactions to even low levels of stimulation. She postulates that if a person is born with a high emotional vulnerability and has poor emotional regulation (i.e., cries easily, angers easily), this leads to emotional dysfunction. However, if this emotional dysfunction is also coupled with an invalidating environment (e.g., trauma or abuse) the combination leads to emotional instability. Therefore, in her view, BPD is a disorder of emotional instability at its core.

Her theory on the criteria of BPD was developed from her clinical experience but it remains consistent with the criteria set forth by the DSM. While Linehan has not redefined the criteria in the DSM, she has reorganized the criteria somewhat. Her reorganization was made to put emphasis on the DSM criteria she found to be most intrusive and common to the borderline population and to group together criteria she found to be conceptually and behaviourally related into five categories. Since a full discussion on each of Linehan's categories is beyond the scope of this paper, this review will only include the category most relevant to the current research – emotional dysregulation. She describes this as:

> primarily a dysfunction of the emotion regulation system; it results from biological irregularities combined with certain dysfunctional environments, as well as their interaction and transaction over time. The characteristics

> associated with BPD are sequalae of, and thus secondary to, this fundamental emotion dysregulation. (Linehan, 1993, p.43)

This category is marked by emotional instability (e.g., reactivity of mood, such as shame, anxiety) and problems with anger (e.g., inappropriate, intense expression of anger). Thus, the inability to successfully regulate and control (stabilize) emotions is seen as the key diagnostic criteria. This category, which focuses on emotions, is of specific interest to the current research.

Shame is considered important by Linehan in the diagnosis of BPD (i.e., as an emotion which the borderline has problems regulating – hence, emotional dysregulation). She also regards shame as an important emotion to consider in the treatment of BPD and states "by its very nature shame interferes with the free flow of therapeutic discourse" (Linehan, 1993, p. 349). Finally, shame is considered an important variable in the hypothesized cause of BPD. Specifically, Linehan (1993) argues that "the shame-reaction – a characteristic response to uncontrollable and negative emotions among borderline individuals" (p. 42) is a result of the individual growing up in an invalidating environment. Shame is considered an important variable in all aspects of BPD, from causation to diagnosis to treatment.

Shame

Guilt and shame are sometimes used interchangeably and many people do not differentiate between these two terms. However, researchers have argued that the two emotions are distinct (Kaufman, 1989; Nathanson, 1996; Welleck, 1993). Shame implies a condition of disgrace, dishonour and humiliation. Shame is a "loss of face . . . is hanging of the head . . . is dishonour, fallen pride, a broken spirit . . .

to live in shame is to feel alienated and defeated, never quite good enough to belong" (Kaufman, 1989, p. 24-25).

Guilt implies an internalization of the moral rules of society and negative emotions arise when these rules are transgressed. Guilt tends to be relieved after a confession and/or apology for the wrongdoing. In contrast, individuals who have a great deal of shame are relatively unforgiving of both themselves and others (Tangney, Fee, Reinsmith, Boone & Lee, 1999). Whereas the guilt-prone person seeks forgiveness to relieve the negative affect, shame seems to provoke irrational retaliative anger as well as externalisation of blame, a defence used to guard against feelings of shame (Tangney, 1995; Tangney et al., 1999; Tangney, Wagner, Barlow, Marschall, & Gramzow, 1996). According to Nathanson (1996), guilt "results from the co-assembly of shame with fear of reprisal or punishment. The fear of punishment, of course, stems from the recognition that one has violated some rule, standard or boundary. The shame experience is much more about the failure of the self" (p. 135).

Shame, as with all human emotions, can range from a transitory affect that is easily managed to a consistent and persistent mood that becomes an inflexible, unchanging and pervasive part of the personality. The concept of *internalized shame* describes a "chronic condition of experiencing "toxic" or "magnified" shame. According to Kaufman, once shame becomes internalized, it forms a major aspect of one's identity and the shame affect becomes essentially autonomous and can be triggered without reference to any interpersonal event" (Kaufman, 1989 as cited in Cook, 2001). The person becomes convinced that they are unlovable, dirty, worthless and hopeless (Balcom, Call & Pearlman, 2000). Internalized shame is experienced as the all-pervasive sense that a person is flawed and defective as a human being.

As Nathanson (1992) asserted, if we ignore shame's effect "on the lives of those who come to us for help, we misunderstand such things as their failure to improve and fall into diagnostic complacency." Viewing shame as an "intense, negative affect . . . internalized into one's sense of self," it becomes possible to explain the puzzling and hard-to-change cluster of symptoms of BPD as the expression of and defenses against the painful emotion of shame (Cook, 2001, p. 1).

Shame, BPD and Psychiatric Symptomatology

In clinical settings, internalized shame can present itself as the primary complaint or as a secondary complaint. Shame can *cause* other symptoms, as when shame leads to an angry outburst during therapy in an attempt to keep the counsellor from questioning about prior abuse, as well as *result* from other symptoms and behaviours (e.g. a person impulsively engaging in self-harm behaviour and then feeling shameful after the episode).

The literature on shame indicates that the continued experience of shame and the reliving of shameful events can lead to poor adjustment. Because of the negative intensity of the emotional state of internalized shame, individuals develop strategies to rid themselves of this feeling, often behaving in ways that lead to depression, acting out, and dissociation (Harder & Lewis, 1986; Lewis, 1992). Often internalized shame is a key component of addictions, anxiety disorders, depression, major mental illness and personality disorders (Balcom, Call & Pearlman, 2000). It is also expected that shame be related to maladaptive coping styles, such as avoidance and attacking the self when faced with difficult situations (Cook, 2001). This underlying, unchanging negative emotion experienced by the individual will be expressed in a plethora of destructive ways.

It is commonly reported that individuals with BPD frequently express inappropriate anger or have difficulty controlling their anger. They may react in impulsive ways, either acting out to attack others (e.g., verbal tirade) or attack inwardly (e.g., self-mutilation). Oftentimes these angry outbursts are followed by "shame and guilt and contribute to the feeling they have of being evil" (APA, 2000, p. 708). Langley (1993) suggests that, while anger and rage are prevalent emotions, we must treat shame as the *core* emotion in BPD.

Linehan's Theory and Shame

According to Linehan, shame occurs when the individual is punished for communicating negative emotions (e.g., anger, hate and disgust) to others. She suggests that shame becomes linked to, and follows, the experiencing of negative emotions in a way that a "vicious cycle is set up, since one effective way to reduce the shame following the negative emotion is to validate the original emotion" (Linehan, 1993, p. 72). This view of shame is consistent with the DSM-IV-TR assertion that shame can follow impulsive, angry outbursts. In essence, shame is considered a primary emotion (i.e., innate) but also can become a secondary emotion that is continuously felt by the individual along with other negative emotions. This secondary function of shame is considered so intolerable that the individual behaves impulsively (i.e., through impulsive anger, self-harm) to negate this distressing emotion of shame.

Linehan and her colleagues conducted two studies to assess the impact of shame on women diagnosed with BPD. In the first study, Brown, Levensky & Linehan (1997), examined thirty-eight women with BPD to determine, in part, if shame was more related to parasuicidal behaviour than other strong positive and negative emotions. The researchers included many emotions in their study, including distress, fear, guilt, enthusiasm and pride. They used a different coding for each emotion, with the coding for shame being the behavioural observation of downcast eyes and lowering of the head during a clinical interview regarding specific questions about parasuicidal incidents. They report that only shame was positively correlated with whether patients parasuicided (r =. 32, p <. 05). The researchers concluded that shame (but not other negative emotions) uniquely predicts whether a patient will parasuicide in the near future and whether a patient will engage in self-mutilation in the near future.

In the second study (Rizvi & Linehan, 2002) the researchers conducted a pilot study utilising a multiple-baseline, single subject design focusing on whether a type of treatment, Dialectical Behaviour Therapy (DBT) reduces the experience of shame. They also hypothesised that a reduction in shame would in turn decrease suicidal behaviour in the women. The results of the pilot study are promising and indicate that shame does decrease with DBT. However, the sample size of the pilot was small (n=9) and the researchers are now conducting a study with a larger sample size.

Goal of the Current Research

The focus of this paper is the relationship between internalized shame and level of psychiatric symptomatology in women diagnosed with BPD. The term psychiatric symptomatology is used here to refer to level of functioning. A high score on measures of psychiatric symptomatology corresponds with a low level of effective day-to-day functioning. Symptom domains used to assess general psychiatric symptomatology include such measures as level of depression (e.g., loneliness, hopelessness), interpersonal sensitivity (e.g., feeling inferior to others) and somatization (e.g., vague physical symptoms). Internalized shame may be at the core of many of the borderline individuals negative behaviours and problems in day-to-day functioning (Langley, 1993; Linehan, 1993; Rizvi & Linehan, 2002).

The question addressed in this research is whether a higher level of internalized shame is related to a higher level of psychiatric symptomatology. To answer this question the levels of shame and psychiatric symptomatology will be measured in a clinical group of female outpatients diagnosed with BPD and compared to a sample of female University students acting as a control group. There are three hypotheses associated with this paper:

Hypothesis One: The BPD patients will report significantly higher levels of internalized shame than the control group.

Hypothesis Two: The BPD patients will report significantly more psychiatric symptomatology than the control group.

Hypothesis Three: The BPD patients reporting higher levels of internalized shame will report greater levels of psychiatric symptomatology than the BPD patients reporting lower levels of internalized shame.

Method

Participants

This project involved the use of a BPD group (*n*=36) and a control group (*n*=49) of adult females. The clinical group were outpatients at an acute care hospital who had the primary diagnosis of Borderline Personality Disorder. They were diagnosed with BPD by a psychiatrist or psychologist using the criteria set forth by the DSM-IV. Additionally, each participant received a score of 8 or higher on the Diagnostic Interview for Borderlines – Revised (DIB-R; Gunderson & Zanarini, 1989). Each of the women in the BPD group was involved in an aftercare program at the hospital that included group therapy, individual counselling and/or doctor's appointments. The control group consisted of University undergraduate students who had never had the diagnosis of BPD. The Cluster B section of the Personality Diagnostic Questionnaire – 4 (PDQ-4; Hyler, 1998) was given to the control group as a screen for BPD. Those women who scored in the clinically significant range were not included in this study.

Criteria for Inclusion

While using selection criteria (e.g., omitting certain persons from participating in the research) ran the risk of resulting in a less pathological population, it was deemed necessary for the present research. Thus, there are five criteria that excluded a person from participating in the BPD group – gender, a current diagnosis of schizophrenia or other psychotic disorder, having less than a grade 8 education, a primary diagnosis that is not BPD, and a score of less than 8 on the DIB-R. First, this research only included female adults. Second, a current diagnosis of schizophrenia or other psychotic disorder is a common exclusion criterion (e.g., Rizvi & Linehan, 2002) because the inclusion of this population tends to decrease the validity of the instruments used (re: due to random responding, inability to focus on the task). Third, the instruments utilized in this study had a minimum reading level and therefore, the participants had at least a grade 8 education to ensure that the instrument was understood. Fourth and fifth exclusion criteria, the person had both the primary diagnosis of BPD given by a psychologist or psychiatrist utilizing the criteria set forth in the DSM-IV as well as a score of 8 or higher on the DIB-R. This was to help better ensure diagnostic accuracy. Conversely, the control group only consisted of those individuals who have never had the diagnosis of BPD. To screen for the presence of BPD, the control sample was given the Cluster B Personality scales of the Personality Diagnostic Questionnaire (PDQ-4). To be included in the study they were required to score below the cutoff for clinical significance on the Borderline Personality Disorder subscale. Using the PDQ-4 results, a total of 2 participants in the control group (3.9% of the total sample) scored in the clinically significant range and were not included in the study. None of the BPD women were excluded from the current study

Participant Characteristics

The mean age for the clinical group was 35.11 years (*SD* = 11.05, range 19-59 years) and consisted of Caucasian (91.7%), Native/Metis (5.6%) and women describing themselves as "Other" (2.7%). The women described their current relationship as single (47.2%), married/common-law (38.9%) and divorced/separated (13.9%). All of the women (100%) reported taking prescription medication. The most commonly reported medications included antidepressants (e.g., Effexor, Wellbutrin, Zoloft), antipsychotics (e.g., Zyprexa), hypnotics (e.g., Imovane), anxiolytics (e.g., Ativan, Rivotril) and birth control pills (e.g., Tricyclene).

The mean age for the control group was 29.39 years (*SD* = 8.62, range 20-54 years) and consisted of Caucasian (89.8%), Asian (4.1%) and "Other" (6.1%). The women described their current relationship as single (57.1%), married/common-law (40.8%) and divorced/separated (2.1%). Forty-five percent of the women reported taking prescription medications. The most commonly reported medications included birth control pills (e.g., Tricyclene, Alesse) and antidepressants (e.g., Effexor).

Measures

The Diagnostic Interview for Borderlines (DIB) was developed as a tool to aid in the diagnosis of BPD by constructing a clinical interview to assess borderline characteristics in patients (Gunderson & Zanarini, 1983). The DIB was revised in 1989 (Zanarini, Gunderson, Frankenberg, & Chauncey, 1989) to sharpen its ability to differentiate between BPD and other personality disorders. The psychometric properties of the Diagnostic Interview for Borderlines-Revised (DIB-R) are similar to those of the original DIB (Gunderson et al., 1981), which has been shown to discriminate among BPD, schizophrenia, and depressive neurosis in adults (Kolb and Gunderson, 1980). It considers symptoms that fall under four main headings: affect (i.e., emptiness, worthlessness), cognition (i.e., nondelusional paranoia), impulse action patterns (i.e., sexual deviance, manipulative suicide gestures, substance abuse) and interpersonal relationships (i.e., dependency, devaluation, demandingness). Inter-rater and test-retest reliabilities indicate kappa's greater than .75 in the diagnosis of BPD. When examining the different symptoms, one-third of the BPD symptoms assessed had a kappa's over .75 and the remaining two-thirds had a fair to good kappa scores (.57-.73) (Zanarini, Frankenburg, & Vujanovic, 2002).

The Personality Diagnostic Questionnaire – 4th Edition (PDQ-4) (Hyler, 1998) is a 100 item, self-administered, true/false questionnaire that yields personality diagnoses consistent with the DSM-IV diagnostic criteria for the axis II disorders. Thus, the PDQ-4 tests for the presence of Cluster A (Paranoid, Schizoid and Schizotypal) Cluster B (Histrionic, Narcissistic, Borderline and Antisocial) and Cluster C (Avoidant, Dependent and Obsessive-Compulsive) personality disorders as well as the Negativistic and Depressive personality disorders. Internal consistency coefficients have ranged in value from .56 (Schizoid) to .84 (Dependent) in a sample of 552 psychiatric patients (Hyler, Rieder, Williams, Spitzer, Lyons, & Hendler, 1989), and 6-month test-retest reliability coefficients have ranged in value from .54 (Histrionic) to .77 (Borderline) in a sample of 44 psychiatric outpatients (Trull & Goodwin, 1993). Good convergent validity was found when comparing the PDQ with the MMPI. For example, the median convergent validity coefficient was .51 (Antisocial) as reported by

Trull (1993). For the purposes of this research only the Cluster B Personality scales were utilized.

The Symptom Assessment – 45 Questionnaire (SA-45) (Strategic Advantages, 2000) is a shortened version of the Symptom Checklist –90 (SCL-90). There are nine symptom domains in the SA-45 designed to assess general psychiatric symptomatology: *Anxiety* (e.g., fearfulness, tension), *Depression* (e.g., hopelessness, loneliness), *Hostility* (e.g., temper outbursts, urges to harm others), *Interpersonal Sensitivity* (e.g., feeling inferior, feeling others are unsympathetic or unfriendly), *Obsessive-Compulsive* (e.g., difficulty concentrating, repetitive checking), *Paranoid Ideation* (e.g., subtle forms of paranoid thinking like others try to take advantage or cannot be trusted), *Phobic Anxiety* (e.g., avoidance, fear of crowds), *Psychoticism* (e.g., disordered thinking, hallucinations) and *Somatization* (e.g., vague physical symptoms). To assess the overall level of pathology or symptomatology, two scales - the *Global Severity Index* (GSI) and *Positive Symptom Total* (PST) are used. GSI is a global measure of the severity of the psychiatric symptoms and PST refers to the number of symptoms present (e.g., answers other than "not at all").

The inventory is scored relative "to a normative database of over 18,000 clinical and nonclinical adults and adolescents, making it one of the best normed instruments of its kind" (Strategic Advantages, 2000, p. xi). Internal consistency and reliability of each of the nine scales was evaluated using Cronbach's alpha, indicating alpha levels ranging from .71 for the psychoticism scale to .92 for the depression scale. Each of the other seven scales had alphas in the .80s. Test-retest reliability after a one-week interval was in the .80s for seven of the nine scales, with two lower correlations occurring for the anxiety scale (.42) and the somatization scale (.69). Construct validity using interscale relationships compared the SA-45 with the SCL-90 in a sample of over 1,300 adult inpatients. The SA-45 coefficients ranged from .38 between the Phobic Anxiety and Hostility scales to .75 between the Interpersonal Sensitivity and Depression scales. Content validity studies for the SA-45 show that each of the individual test items demonstrate its strongest relationship with the scale to which it belongs. For example, using the item-total correlations for the adult inpatient sample, correlations ranged from a low of .29 for the item in the psychoticism scale to a high of .80 for an item in the depression scale. Most item-total correlations were in the .60s and .70s (Strategic Advantages, 2000).

The Internalized Shame Scale (ISS) (Cook, 2001) is a 30-item self-report Likert-type scale composed of 24 items that measure shame and six items that measure self-esteem. The six self-esteem items are an adaptation of the 10-item Rosenberg Self-Esteem Scale (Rosenberg, 1965). The ISS was developed to identify, not the momentary experience of shame, but the enduring constellation of shame feelings that result from frequent shaming experiences that have become internalized over time.

The internal consistencies for item-total correlations were reported at alpha's ranging from .52 to .82 with a median correlation of .70. The alpha reliability coefficient of .96 indicates the items are very high in internal consistency. Further, because of the theoretical underpinnings of the instrument, namely, the idea that shame is a toxic (biological) risk factor in the development of psychopathology, the

ISS was correlated with numerous measures of psychopathology. These measures included the SCL-50 ($r = .77$), the Beck Depression Inventory ($r = .62$ to $r = .79$ depending on the sample), Suicide Probability Scale ($r = .52$ to $r = .81$ depending on the subtest), and the State-Trait Anger Expression Inventory ($r = .22$ to $r = .57$, depending on the subtest). Convergent validity correlations ranged from .45 to .74 when comparing the ISS to psychopathology variables obtained from the Brief Symptom Checklist.

The Participant Information Questionnaire is a brief, two-page, self-administered questionnaire developed by the author to assess participant demographics and other information deemed important to this research. The questionnaire is similar to those commonly used during an intake procedure and covers such areas as prescription medication currently used, hospitalisations, marital status and level of educational attainment. The questionnaire consists of fill in the blank, multiple choice and yes/no responses.

Procedure

A slightly different procedure was used for each sample. Approximately one to two weeks before the expected data collection date the women in the clinical group were given an Information Letter that explained the purpose and time commitment of the study, risks and benefits and participant rights. Those women who chose to participate were given a package containing the instruments used by this group. All women had previously been given the DIB-R by their psychiatrist upon admission to the aftercare program and had obtained a score of 8 or higher on the instrument. All the participants in the clinical group were tested within the same week at the same location (the hospital) by the same researcher. The time required to complete the questionnaires took between 20 minutes and 60 minutes. Two of the women refused to participate for a refusal rate of 5.3%.

The control group consisted of students from two University undergraduate classes. During a designated class time, the researcher handed out an Information Letter and reviewed it with the class. Those students who chose to participate were given a package containing the instruments utilized for this group. Both of the undergraduate classes were tested within the same week and in the same building at the University by the same researcher. The time required to complete the questionnaires took between 15 minutes and 45 minutes. The refusal rate for this group was 10.9%

All of the participants were treated in a manner consistent with the ethical guidelines set out by both the University of Alberta and the Capital Health Authority. Ethics approval from the University of Alberta Faculties of Education and Extension Research Ethics Board and the University of Alberta Health Sciences Faculties, Capital Health Authority and Caritas Health Group Research Ethics Board (Panel B) was obtained.

Results

Hypothesis One

Internalized shame was assessed using the Internalized Shame Scale (ISS). Descriptive statistics and test statistics for the BPD and control groups are both reported. An alpha level of .01 was used for all statistical tests. The results were analyzed using an independent samples t-test. Levene's test for equality of variances indicated that the equal variances could be assumed using the ISS ($F = 1.38$, $p = .433$).

The ISS allows the quantitative responses to be categorized as falling into three different levels of shame – low shame (scores of 49 or lower), frequent experience of shame (scores between 50-59) and high levels of shame (scores of 60 or higher). For the women in the BPD group, 19.4% were categorized as having low shame, 16.7% as having frequent shame and 63.9% as having high shame. In contrast, within the control group, 91.8% were categorized as having low shame, 6.1% as having frequent shame and 2.0% as having high shame.

The mean ISS score for the BPD group ($n = 36$) was 64.17 ($SD = 16.98$). The mean ISS score for the control group ($n = 49$) was 24.29 ($SD = 14.77$). The difference between the mean shame scores for the two groups is statistically significant, $t\ (83) = 11.54$, $p < .01$.

The ISS also includes a measure of self-esteem taken from the Rosenberg Self-Esteem Scale (Rosenberg, 1965). While the main purpose of including these items was to "circumvent the problem of response bias, given that all the shame items are phrased in the negative direction" (Cook, 2001, p.12) the authors suggest that a score of 18 or higher indicates a high self esteem while scores under 18 suggest a low self esteem. The difference between the self-esteem scores for the BPD group ($M = 10.17$, $SD = 5.07$) and the control group ($M = 18.27$, $SD = 3.84$) were found to be statistically significant, $t\ (83) = 8.38$, $p < .01$. Hypothesis one is supported. The BPD patients reported significantly higher levels of internalized shame than the control group. Furthermore, they had lower levels of self-esteem.

Hypothesis Two

Psychiatric symptomatology (or level of functioning) was assessed using the Symptom Assessment - 45 (SA-45). Descriptive statistics and test statistics for the clinical (*n* = 36) and control (*n* = 49) groups are both reported in Table 2-1. An alpha level of .01 was used for all statistical tests. The results were analyzed using an independent samples t-test. The scales for the SA-45 are reported using t-scores. In all eleven scales, there were significant differences found between the scores of the control group and clinical group. Hypothesis two is supported - the BPD patients reported significantly more psychiatric symptomatology than the control group.

Table 2-1

Comparison of BPD and Control Group Scores on Psychiatric Symptomatology

	BPD Group		Control Group		t-test
Measure	*M*	*SD*	*M*	*SD*	*t*
GSI	73.28	8.45	56.53	7.47	9.66*
PST	72.47	7.62	58.30	7.19	8.75*
Anxiety	74.22	6.48	57.14	6.48	10.37*
Depression	71.14	7.39	56.96	6.39	9.46*
Obsessive	73.69	9.52	58.10	8.33	8.02*
Somatization	68.72	9.98	55.53	6.59	7.34*
Phobic	72.00	7.53	61.65	4.99	7.62*
Hostility	68.06	7.69	58.04	5.74	6.88*
Interpersonal	68.61	7.73	57.65	6.01	7.35*
Paranoid	65.67	9.31	54.86	8.05	5.72*
Psychoticism	69.56	9.17	61.47	4.22	5.44*

Note. GSI refers to Global Severity Index. PST refers to Positive Symptom Total.
* $p < .01$.

Psychiatric Symptomatology and Internalized Shame

Further investigation of the relationship between shame and psychiatric symptomatology was conducted by correlating the internalized shame scores (from the ISS) with level of psychiatric symptomatology (the scales of the SA-45) for both groups. This was completed using a bivariate, one-tailed Pearson product-moment correlation with an alpha level of .01. The results are listed in Table 2-2. As illustrated, internalized shame was significantly positively correlated with all the scales of the SA-45 for both groups with the lone exception of the scale *Somatization* for the BPD group (*r* (35) = .30, *p* = .04).

Table 2-2

Correlations between Internalized Shame and Psychiatric Symptomatology for the BPD and Control groups

Measure	Clinical Group Shame Score	Control Group Shame Score
GSI	.68	.78
PST	.60	.60
Anxiety	.67	.64
Depression	.71	.68
Obsessive-Compulsive	.65	.56
Somatization	.30*	.39
Phobic	.41	.39
Hostility	.47	.58
Interpersonal Sensitivity	.76	.67
Paranoid Ideation	.64	.72
Psychoticism	.64	.55

Note. GSI refers to Global Severity Index. PST refers to Positive Symptom Total.
* p > .01.

Hypothesis Three

To address hypothesis three, the BPD group was divided into two groups. The first group consists of women who reported high levels of shame. The second group consisted of women who reported low levels of shame. To obtain these groups women scoring in the highest and lowest 25% on the ISS were used.

In the high shame group (n=9) the average shame score was *M* = 84.33 (*SD* = 4.33). Conversely, in the low shame group (n=9) the average shame score was *M* = 41.78 (*SD* = 7.90). Levene's test for equality of variance indicated that equal variances could be assumed for all comparisons. To test whether the BPD women with low shame and high shame differed in levels of psychiatric symptomatology a t-test for independent samples was utilized with an alpha level of .01.

As noted in Table 2-3 there were significant differences in level of psychiatric symptomatology by shame level. It was found that the low shame group scored lower on all the eleven scales than the high shame group. Statistically significant differences were found for all the scales at the .01 level with the exception of the scales measuring *Somatization* (t (16) = 1.02, p = .32), *Phobic Anxiety* (t (16) = 2.71, p = .02) and *Hostility* (t (16) = 2.75, p = .014).

Overall, hypothesis three is supported - the BPD patients reporting higher levels of internalized shame reported greater levels of overall psychiatric symptomatology than the BPD patients reporting lower levels of internalized shame.

Table 2-3

Comparison of BPD Women with High Shame Scores and Low Shame Scores on Measures of Psychiatric Symptomatology

Measure	Shame Level	*M*	*SD*	*t*	*p*
GSI	Low Shame	64.78	8.23	4.27	.001
	High Shame	78.22	4.66		
PST	Low Shame	65.11	7.88	3.65	.002
	High Shame	76.00	4.24		
Anxiety	Low Shame	67.11	6.17	4.43	.001
	High Shame	78.11	4.17		
Depression	Low Shame	63.22	4.99	6.03	.001
	High Shame	76.22	4.12		
Obsessive	Low Shame	66.33	8.11	3.49	.003
	High Shame	78.11	6.05		
Somatization	Low Shame	63.00	13.46	1.02	.321*
	High Shame	68.33	7.94		
Phobic	Low Shame	67.44	6.60	2.71	.015*
	High Shame	75.89	6.60		
Hostility	Low Shame	62.78	6.98	2.75	.014*
	High Shame	71.78	6.92		
Interpersonal	Low Shame	60.44	7.14	5.09	.001
	High Shame	74.78	4.52		
Paranoid	Low Shame	57.11	8.52	4.53	.001
	High Shame	73.33	6.54		
Psychoticism	Low Shame	61.89	5.18	3.38	.004
	High Shame	73.56	8.96		

Note: GSI refers to Global Severity Index. PST refers to Positive Symptom Total.
* $p > .01$.

Discussion

As expected, the reported levels of internalized shame experienced by the women diagnosed with BPD were significantly higher than a control group of women. Indeed, 80% of the BPD group reported feeling frequent or high levels of internalized shame, compared to only 8% of the control group. This supports the recent assertion of researchers that internalized shame is an emotion which has particular relevance to the borderline population (Brown, Levensky & Linehan, 1997; Rizvi & Linehan, 2000). The clear finding from this study was that there is a great deal of difference between BPD women and women without this diagnosis in their level of internalized shame.

Another expected significant difference between the two groups was their level of psychiatric symptomatology, or ability to function effectively day-to-day. The BPD group scored significantly higher than the control group on all measures on the SA-45. Some of these measures included symptoms such as anxiety, depression, phobias, hostility and interpersonal sensitivity. The BPD women in this study still appear to have many psychological issues that make functioning in society difficult for them. This difficulty is further understood when we examine both psychiatric symptomatology and internalized shame together.

We must keep in mind that internalized shame is described as the all pervasive sense that a person is flawed and defective as a human being and that the BPD women may use a variety of defences to guard against the feeling of internalized shame (Balcom, Call & Pearlman, 2000; Lewis, 1992; Nathanson, 1996). Thus in this study BPD women scoring the highest on levels of internalized shame were compared to the BPD women scoring lowest on levels of internalized shame on measures of psychiatric symptomatology. The women with the highest internalized shame also reported the highest level of psychiatric symptomatology (or low day-to-day functioning). Conversely, those women scoring the lowest on internalized shame also scored the lowest on psychiatric symptomatology. Level of internalized shame was significantly correlated with psychiatric symptomatology. The exception to this pattern was found on three scales: somatization (presence of vague physical symptoms), phobic anxiety (symptoms of avoidance, fear of crowds) and hostility (e.g., getting into frequent arguments, shouting) (Strategic Advantages, Inc., 2000).

For this study, an alpha of .01 was used as an index of significance. This is fairly stringent. So, it is important to note that for two of the scales, phobic anxiety and hostility, significance was found at the .05 level but this did not meet the requirements set out in this research. Nonetheless, it is surprising that hostility was not found to have a stronger relationship with internalized shame as this runs counter to the assertions made in other studies (e.g., Linehan, 1993; Tangney, Wagner & Gramzow, 1992). There are two possible reasons for this finding. First, it is often reported that men express anger outwardly while women are more likely to express anger inwardly (Cook, 2001). While this may be the case for many populations, it does not seem likely this is the reason as the BPD population is known for having difficulties controlling their anger and angry outbursts. Indeed, anger is part of the diagnostic criteria for the disorder (APA, 2000). The hypothesis that anger is being used as a defence against shame is more likely. Those women reporting hostile emotions are actually guarding against the painful emotion of internalized shame. The role of anger as a coping strategy to avoid feeling of shame has support in the literature (APA, 2000; Langley, 1993; Linehan, 1993).

The scale of somatization was also not significantly correlated with internalized shame. This may be because of the nature of the scale, which measures physical complaints that are not related to a medical condition. Since a complete medical history was not taken of the participants, it is not possible to ascertain whether there are legitimate medical problems within this sample that could skew the results for this scale. Furthermore, according to Cook (2001), there is no theoretical reason why the symptoms of somatization should be related to internalized shame.

Overall, the results indicate that internalized shame is a prominent emotion experienced by the BPD women. However, we must resist the urge to group all BPD women into one homogenous group. While 80% of BPD women surveyed in this study reported frequent to high levels of internalized shame, there was a sizeable minority of BPD women for whom internalized shame was not reported as a prominent emotion.

Conclusion and Future Directions

The purpose of this study was to examine the role of internalized shame in women with BPD. One way to look at the impact of a particular negative emotion is to examine the level of the emotion and a person's psychiatric symptomatology (level of functioning). The BPD women appear to have both poor day-to-day functioning and higher levels of internalized shame than women without BPD. Further, within the BPD group, internalized shame was found to be positively correlated with psychiatric symptomatology. In other words, those with the highest internalized shame also reported the most psychiatric symptomatology.

Thus, with a significant portion of BPD women reporting high levels of internalized shame there appears to be a need for treatment focused on reducing this negative emotion within this population and teaching women effective, healthy ways to cope with internalized shame. One treatment method developed by Linehan (1993) attempts to address the impact of this emotion in the BPD population. During treatment Linehan (1993) asserts that

> the interpersonal events that reinforce shame are ostracism, rejection and the loss of the respect of others. Thus, it is particularly important when a patient is revealing shameful material the therapist responds with validation as opposed to censure, with acceptance rather than rejection. In particular, the therapist should be alert to the fact that disclosing shameful events is itself shaming. (p.349)

There are two main questions that arise from the current study that need to be addressed in further research. The first question centres on the relationship between internalized shame and anger within the BPD population. The research is limited and contradictory on this topic with most of the literature consisting of anecdotal reports rather than empirical studies. While recently some researchers have argued that anger is used as a defence against shame (Langley, 1993; Linehan 1993; Tangney et al., 1999) this still requires more research as to the magnitude and specificity of this relationship.

The second question evolving from this research is further understanding how the BPD women with low internalized shame differ from those BPD women with high internalized shame. The results of this study suggest that 20% of the BPD women report low shame. In addition, these women appeared to have a higher level of functioning than their peers who reported higher levels of shame. What accounts for the difference between the two groups? Does treatment play a role? Or is it linked to their life histories and the occurrence, or lack of occurrence, of shame-evoking experiences (such as trauma)? More research needs to be conducted to address these issues.

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CHAPTER 3

THE RELATIONSHIP BETWEEN TRAUMA, INTERNALIZED SHAME AND PSYCHIATRIC SYPMPTOMATOLOGY IN WOMEN DIAGNOSED WITH BORDERLINE PERSONALITY DISORDER

Purpose

The focus of this paper is the relationship between trauma, internalized shame and psychiatric symptomatology in women diagnosed with Borderline Personality Disorder. The variable of trauma, as used in this study, includes all types of traumatic events and does not focus specifically on sexual abuse. While it is recognised that sexual abuse is commonly reported within the borderline population (Kroll, 1993) it is proposed here that one traumatic event is not "more traumatic" than another. It is argued that it is the individual's response to the trauma that is most important in determining the impact of the trauma. In other words, regardless of the type of trauma suffered (e.g., sexual abuse, physical abuse, death of parent) the individual's emotional reaction (specifically, the emotion of shame) is the most important factor in determining the BPD individual's level of psychiatric symptomatology.

Review of the Literature

BPD occurs in approximately 11% of outpatient and 19% of psychiatric inpatient populations (Berber, 1997). The prevalence of BPD in the general population is estimated at 1.8 - 3%, depending on the population studied (APA, 2000; Berber, 1997; Widiger & Weissman, 1991). One figure that does remain consistent in the various studies is a considerable gender difference in the diagnosis of BPD, with approximately 75% of those diagnosed being female. The largest population first diagnosed with BPD is women between 18 and 30 years of age (American Psychiatric Association (APA), 2000; Hubbard, Saathoff, Bernardo, & Barnett, 1995; Linehan, 1993). This gender difference is usually explained by cultural or societal factors. Namely, women who display impulsive, angry and manipulative behaviours are diagnosed as borderline, while males with similar features are more often diagnosed with Antisocial Personality Disorder. However, researchers speculate that the greater number of females diagnosed with BPD reflects the combined effect of more girls than boys being exposed to trauma in childhood (especially sexual abuse) and of the tendency of females to express emotional instability via self-destructiveness rather than via aggression toward others. Indeed, a majority of women who have BPD also have a history of early sexual abuse (APA, 2000; Hubbard et al., 1995; Linehan, 1993).

The prevalence of sexual abuse in women is about 10-20% in the general population, 20-50% in the psychiatric population and 60-80% in the borderline population (Kroll, 1993). The high rates of sexual abuse in BPD women has led researchers to question the underlying emotional disturbance and the co-occurring instability caused by such abuse. Most researchers agree that individuals with BPD have associated features (attributes) that are not part of the DSM-IV-TR definition but are common to the disorder. Similarly, individuals who were sexually abused may have many of the symptoms of BPD without meeting the full criteria for the disorder. What is important to note is that some of the key symptoms of BPD may be directly related to trauma. For instance, adult patients with histories of childhood sexual abuse often present symptoms of impulsivity, self-destructive behaviour, substance abuse, identity disturbance, and depression, symptoms that appear in the DSM-IV-TR criteria for BPD (APA, 2000; Westen, Ludolph, Misle, Ruffins, & Block, 1990).

Further, in one Canadian study, 88 inpatients diagnosed with BPD were compared with 42 inpatients matched for socioeconomic class and education level. The researchers found that the patients with BPD were significantly more likely to have been victims of sexual abuse by caretakers (Links, Steiner, Offord, & Eppel, 1988). This knowledge makes the understanding of the borderline patients history essential since "many borderlines react to themselves with extreme loathing bordering on self-hate. All but a few feel enormous shame about their own abuse history, the troubles they have caused, and their present emotional reactivity in particular" (Linehan, 1993, p. 160).

The often-cited link between childhood sexual abuse and BPD has led some researchers to postulate that BPD is a manifestation of Post Traumatic Stress Disorder (PTSD). One theory, proposed by Kroll (1993), supports the idea that there is an overlap between BPD and PTSD. He argues that those with a strong history of childhood trauma could be classified as having chronic PTSD. Kroll has proposed a new label for this clinical group, called "PTSD/Borderline". However, as Paris (1994) notes "this formulation is highly premature given our lack of knowledge about the etiology of BPD . . . PTSD is one of the few Axis I diagnoses in which a specific cause is built into its definition . . . to redefine BPD as a PTSD would be to assume we know the etiology of BPD when we do not" (p.9). Kroll (1993) acknowledges this dilemma and admits that, “we do not know yet how to relate the many different causes and presentations of PTSD to each other, and do not know how it comes about that borderlines who have and have not been abused resemble each other” (p. 70). In other words, since not all individuals diagnosed with BPD and PTSD have histories of childhood sexual abuse, the linking of the two disorders seems premature at this time. However, the idea that there was trauma in the BPD patients’ past that acts as a risk factor in the development of the disorder is well supported.

Thus, the psychological risk factor most commonly espoused for BPD is that of trauma, whether it is sexual abuse or another distressing event (Davidson, 1996). A trauma, as defined in the DSM-IV-TR, is an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, and induced a response of intense fear, helplessness or horror (APA, 2000). Such events are outside of everyday experience and are markedly distressing to the great majority. There are many emotions that may result from a traumatic event, including guilt, anger, self-destructiveness, and impulsive behaviour (APA, 2000). There also may be a great deal of shame. In fact, it has been argued that virtually all traumatized patients have some degree of internalized shame (Courtois, 1992).

One large study found that the most significant differences in levels of pathology between a control group and borderline group were obtained by combining all forms of abuse into a “total trauma score” (Paris, 1994, p.60). Research by Margo and McLees (1991) support this finding with their study of 38 females in a psychiatric facility. They observed that women with trauma histories scored higher on the SCL-90 on scales for anxiety, hostility, depression, somatization and global severity index than those without such histories. They stated that childhood abuse of any type (physical, sexual or both) is a significant risk factor for severity of psychiatric symptoms.

Although trauma is a commonly documented feature in the life history of women with BPD, it is generally considered a risk factor for the disorder rather than a causal mechanism. While most theorists do not subscribe to the idea that there is only one cause of BPD, they do feel there are certain factors that put a person "at risk" for developing the disorder. The psychological risk factors "are related to a variety of childhood experiences and fall into three general categories: trauma, early separation or loss, and abnormal parenting . . . although, trauma seems to be more specific to BPD" (Paris, 1994, p.43). Research by Paris, Zweig-Frank and Guzder (1994) examined the abuse histories of 78 women with BPD and compared them to 72 women with a personality disorder other than BPD. They found that most childhood sexual abuse occurred only one time and that those patients with BPD and a history of childhood sexual abuse were found to have "a variety of experiences, some more or less traumatic" (p. 378). One possible explanation for the lack of specificity for childhood sexual abuse in BPD is that childhood experiences have a different impact depending on how they are processed by the individual (Rutter & Rutter, 1993).

In a study of adult women who were sexually abused as children, researchers found that feelings of shame mediated the relationship between the severity of the abusive events and current psychological distress (Coffey, Leitenberg, Henning, Turner, & Bennet, 1996). In other words, women who reported feeling highly shamed from past abuse had higher levels of pathology (or psychiatric symptomatology). This finding is supported by investigations of the long-term consequences of child sexual abuse that demonstrate a connection in female patients between a history of trauma (sexual abuse) and BPD (Silk & Lee, 1995; Trull, 2001; Westen et al., 1990). Of course, these researchers do not imply that childhood sexual abuse causes BPD, rather, that the combination of trauma, emotional instability (Linehan, 1991) and high levels of internalized shame may make an individual more susceptible to develop BPD.

Shame

Although guilt and shame are sometimes used interchangeably and lay people see little difference between them, researchers have argued that the two emotions are distinct (Kaufman, 1989; Nathanson, 1996; Welleck, 1993). Shame implies a condition of disgrace, dishonour and humiliation. It is a strong emotion caused by feelings of unworthiness and causes the individual to be unable or uncomfortable around others because of their actions.

Guilt implies an internalisation of the moral rules of society and negative emotions arise when these rules are transgressed. Guilt tends to be relieved after a confession and/or apology for the wrongdoing. In contrast, individuals who have a great deal of shame are relatively unforgiving of both themselves and others (Tangney, Fee, Reinsmith, Boone & Lee, 1999). Further, shame seems to provoke irrational retaliative anger as well as externalisation of blame, a defence used to guard against feelings of shame (Tangney, 1995; Tangney et al., 1999; Tangney, Wagner, Barlow, Marschall, & Gramzow, 1996). According to Middleton-Moz

(1990) there are many factors that have contributed to the historical confusion of guilt and shame. She offers the following summary to clarify the difference between shame and guilt:

> 1. Because of the isolating nature of shame, it is easier to express feelings of guilt.
> 2. There is more personal power in the experience of guilt. We feel guilt for what we have done or not done and, therefore, have control over our future choices. When we experience shame, we feel helplessness and powerlessness.
> 3. When we experience guilt, we may fear punishment but when we are punished or have made amends the guilt is resolved. When we experience shame, we fear abandonment.
> 4. Feelings of shame and guilt frequently occur together . . . this primarily applies to debilitating guilt rather than appropriate guilt.
> 5. We often feel ashamed of our shame. Although we may fear punishment, there is usually relief in confessing guilt. The fear of further abandonment often prevents the expression of shameful experiences or even the conscious awareness of shameful feelings. (pp. 55-56)

Shame, as with all human emotions, can range from a transitory affect that is easily managed to a consistent and persistent mood that becomes an inflexible, unchanging and pervasive part of the personality. The concept of *internalized shame* depicts an extreme and intense sense of shame as a chronic aspect of identity, as distinct from the emotion of shame, which although sometimes intense, is transitory

(Balcom et. al, 2000). Internalized shame permeates a person's life as the filter through which all experience is perceived (Spero, 1984; Thrane, 1979) and the person becomes convinced that they are unlovable, dirty, worthless and hopeless (Balcom, Call & Pearlman, 2000). Internalized shame is experienced as the all-pervasive sense that a person is flawed and defective as a human being. It is no longer an emotion that signals limits; it is a state of being, a core identity.

The literature on internalized shame indicates that the continued experience of shame and the reliving of shameful events can lead to poor adjustment. Because of the negative intensity of the emotion, individuals develop strategies to rid themselves of this feeling, often behaving in ways that lead to depression, acting out, and dissociation (Harder & Lewis, 1986; Lewis, 1992). Oftentimes, internalized shame is a key component of addictions, anxiety disorders, depression, major mental illness and personality disorders (Balcom, Call & Pearlman, 2000). It has been hypothesized that virtually all traumatized patients have some degree of internalized shame (Courtois, 1992).

Summary

Overall, the literature is divided on whether one traumatic event (i.e., sexual abuse) can be considered more traumatic than another event (e.g., death of a family member) or if the effect of the trauma is dependent on the response of the individual. In this study, it is postulated that while trauma, and sexual abuse in particular, “represent psychological risk factors in the development of BPD, the magnitude of their effects are not specific and probably depend on multiple interacting factors, such as . . . temperament . . . and the existence of additional biological and psychological risk factors" (Adams, Bernat & Luscher, 2001). One of these risk factors may be the level of internalized shame experienced by the person traumatized, regardless of the type of trauma. As mentioned previously, researchers have demonstrated that feelings of internalized shame can mediate the relationship between the severity of the traumatic events and current psychological distress (Coffey et al., 1996). Thus, a recent way of understanding the effects of trauma is to obtain not only the victims overall level of trauma, but also their experience of symptoms such as intrusion (re-experiencing the event), avoidance/numbing (e.g., restricted range of affect) and hyperarousal (e.g., hyper vigilance) (Davidson, 1996). It may not be about the traumatic event so much as it is about the individual's emotional reaction to it.

Goal of the Current Research

This paper focuses on the question: What is the relationship between trauma, internalized shame and psychiatric symptomatology in women diagnosed with BPD as compared to a control group of undergraduate university women? There are four hypotheses in this paper:

Hypothesis One: In both the BPD group and the control group, a higher degree of trauma will be correlated with higher internalized shame.

Hypothesis Two: In both the BPD group and the control group, a higher degree of trauma will be correlated with higher levels of psychiatric symptomatology.

Hypothesis Three: The BPD group will report a higher degree of trauma than the control group.

Hypothesis Four: The degree of trauma reported by those individuals who were sexually abused will *not* differ from trauma reported by those whose traumatic event was not sexual abuse.

Method

Participants

This project involved the use of two different samples, a BPD group (n=36) and a control group (n=49). Both of the groups consist only of adult females. The BPD group consists of outpatients at an Alberta hospital who have the primary diagnosis of BPD. They were diagnosed with BPD by a psychiatrist or psychologist using the criteria set forth by the DSM-IV. Additionally, each participant received a score of 8 or higher on the Diagnostic Interview for Borderlines – Revised (Diagnostic Interview for Borderlines – Revised (DIB-R); Gunderson & Zanarini, 1983). Each of the women in the BPD group was involved in an aftercare program at the hospital that includes group therapy, individual counselling and/or doctor's appointments. The control group consisted of University undergraduate students who have never had the diagnosis of BPD. The Cluster B section of the Personality Diagnostic Questionnaire – 4 (PDQ-4) (Hyler, 1998) was given to the control group as a screen for BPD. Those women who scored in the clinically significant range were not included in this study. Using the PDQ-4 results, a total of 2 participants in the control group (3.9% of the total sample) scored in the clinically significant range and were not included in the study.

While using selection criteria (i.e., omitting certain persons from participating in the research) runs the risk of resulting in a less pathological population, it is deemed necessary for the present research. Thus, there are five criteria that excluded a person from participating in the BPD group: gender (only females are included in the study), a current diagnosis of schizophrenia or other psychotic disorder, having less than a grade 8 education, a primary diagnosis that is not BPD, and a score of less than 8 on the DIB-R. Conversely, the control group consists of those individuals who have never had the diagnosis of BPD. As mentioned, to screen for the presence of BPD, the control sample was given the Cluster B personality scales of the PDQ-4. To be included in the study they were required to score below the cutoff for clinical significance on the cluster B subscales.

Participant Characteristics

The mean age for the BPD group was 35.11 years (*SD* = 11.05, range 19-59 years) and consisted of Caucasian (91.7%), Native/Metis (5.6%) and those women considered themselves as falling in the category of "Other" (2.7%). The women described their current relationship as single (47.2%), married/common-law (38.9%) and divorced/separated (13.9%). All of the women (100%) reported taking prescription medication. The most commonly reported medications included antidepressants (e.g., Effexor, Wellbutrin, Zoloft), antipsychotics (e.g., Zyprexa), hypnotics (e.g., Imovane), anxiolytics (e.g., Ativan, Rivotril) and birth control pills (e.g., Tricyclene).

The mean age for the control group was 29.39 years (*SD* = 8.62, range 20-54 years) and consisted of Caucasian (89.8%), Asian (4.1%) and those women considered themselves as falling in the category of "Other" (6.1%). The women described their current relationship as single (57.1%), married/common-law (40.8%) and divorced/separated (2.1%). Forty-five percent of the women reported taking prescription medications. The most commonly reported medications included birth control pills (e.g., Tricyclene, Alesse) and antidepressants (e.g., Effexor).

Measures

This study utilises six different testing instruments. These include the Diagnostic Interview for Borderlines – Revised (DIB-R), Personality Diagnostic Questionnaire (PDQ-4), The Symptom Assessment – 45 Questionnaire (SA-45), Internalized Shame Scale (ISS), Davidson Trauma Scale (DTS) and the Participant Information Questionnaire. The six instruments are described briefly below.

The Diagnostic Interview for Borderlines – Revised (Diagnostic Interview for Borderlines – Revised (DIB-R); Gunderson & Zanarini, 1983) was developed as a tool to aid in the diagnosis of BPD by constructing a clinical interview to assess borderline characteristics in patients. The DIB was revised in 1989 (Zanarini, Gunderson, Frankenberg, & Chauncey, 1989) to sharpen its ability to differentiate between BPD and other personality disorders. It considers symptoms that fall under four main headings: affect (i.e., emptiness, worthlessness), cognition (i.e., nondelusional paranoia), impulse action patterns (i.e., sexual deviance, manipulative suicide gestures, substance abuse) and interpersonal relationships (i.e., dependency, devaluation, demandingness). Inter-rater and test-retest reliabilities indicate kappa's greater than .75 in the diagnosis of BPD. When examining the different symptoms, one-third of the BPD symptoms assessed had a kappa's over .75 and the remaining two-thirds had a fair to good kappa scores (.57-.73) (Zanarini, Frankenburg, & Vujanovic, 2002).

The Personality Diagnostic Questionnaire – 4th Edition (PDQ-4) (Hyler, 1998) is a 100 item, self-administered, true/false questionnaire that yields personality diagnoses consistent with the DSM-IV diagnostic criteria for the axis II disorders. Internal consistency measures are acceptable and fall in alphas of .70 (Wilberg, Dammen & Friis, 2000). The measure has demonstrated good specificity and sensitivity, but does have a relatively high false positive rate, especially for the Histrionic scale (Lyoo, Youn, Ha, Park & Kwon, 2003; Wilberg et. al., 2000). For the purposes of this research only the Cluster B Personality scales (Histrionic, Narcissistic, Borderline and Antisocial) were utilized. Internal consistency coefficients have ranged in value from .56 (Schizoid) to .84 (Dependent) in a sample of 552 psychiatric patients (Hyler Hyler, Rieder, Williams, Spitzer, Lyons, & Hendler, 1989), and 6-month test-retest reliability coefficients have ranged in value from .54 (Histrionic) to .77 (Borderline) in a sample of 44 psychiatric outpatients (Trull & Goodwin, 1993). Good convergent validity was found when comparing the PDQ with the MMPI. For example, the median convergent validity coefficient was .51 (Antisocial) as reported by Trull (1993).

The Symptom Assessment – 45 Questionnaire (SA-45) (Strategic Advantages, 2000) is a 45-item scale developed as a "brief yet comprehensive general assessment of psychiatric symptomatology" (Strategic Advantages, 2000, p.1). The SA-45 is a shortened version of the Symptom Checklist –90 (SCL-90). There are nine symptom domains in the SA-45: *Anxiety* (e.g., fearfulness, tension), *Depression* (e.g., hopelessness, loneliness), *Hostility* (e.g., temper outbursts, urges to harm others), *Interpersonal Sensitivity* (e.g., feeling inferior, feeling others are unsympathetic or unfriendly), *Obsessive-Compulsive* (e.g., difficulty concentrating, repetitive checking), *Paranoid Ideation* (e.g., subtle forms of paranoid thinking like others try to take advantage or cannot be trusted), *Phobic Anxiety* (e.g., avoidance, fear of crowds), *Psychoticism* (e.g., disordered thinking, hallucinations) and *Somatization* (e.g., vague physical symptoms). To assess the overall level of pathology or symptomatology, two scales - the *Global Severity Index* (GSI) and *Positive Symptom Total* (PST) are used. The PST index is the "total number of symptoms reported to be present (i.e., items yielding a response other than "Not at all"). The GSI . . . provides an overview of the respondents level of symptomatology" (Strategic Advantages, Inc., 2000; p.2).

Internal consistency and reliability of each of the nine scales was evaluated using Cronbach's alpha, indicating alpha levels ranging from .71 for the psychoticism scale to .92 for the depression scale. Each of the other seven scales had alphas in the .80s. Test-retest reliability was assessed using a nonclinical sample to lessen the possible confounding effects of treatment and to rule out measuring symptoms that are transient, which is a common occurrence in hospital and treatment centres. The correlations after a one-week interval were in the .80s for seven of the nine scales, with two lower correlations occurring for the anxiety scale (.42) and the somatization scale (.69) (Strategic Advantages, 2000).

Construct validity using inter-scale relationships compared the SA-45 with the SCL-90 in a sample of over 1,300 adult inpatients. The SA-45 coefficients ranged from .38 between the Phobic Anxiety and Hostility scales to .75 between the

Interpersonal Sensitivity and Depression scales. Content validity studies for the SA-45 show that each of the individual test items demonstrate its strongest relationship with the scale to which it belongs. For example, using the item-total correlations for the adult inpatient sample, correlations ranged from a low of .29 for an item in the psychoticism scale to a high of .80 for an item in the depression scale. Most item-total correlations were in the .60s and .70s (Strategic Advantages, 2000).

The Internalized Shame Scale (ISS) (Cook, 2001) is a 30-item self-report Likert-type scale composed of 24 items that measure shame and six items that measure self-esteem. The six self-esteem items are an adaptation of the 10-item Rosenberg Self-Esteem Scale (Rosenberg, 1965). The internal consistencies for item-total correlations were reported at alpha's ranging from .52 to .82 with a median correlation of .70. The alpha reliability coefficient of .96 indicates the items are very high in internal consistency. Convergent validity was tested using the Rosenberg Self-Esteem scale and the total score from the Tennessee Self-Concept Scale. The correlations between the shame scale and the self-esteem scales were $r = -.90$ and $r = -.66$ respectively. Further, the ISS was correlated with numerous measures of psychopathology to establish construct and predictive validity. These measures included the SCL-50 ($r = .77$), the Beck Depression Inventory ($r = .62$ to $r = .79$ depending on the sample) and the Suicide Probability Scale ($r = .52$ to $r = .81$ depending on the subtest).

The Davidson Trauma Scale (DTS; Davidson, 1996) is a 17-item, self-report instrument used to measure the severity of traumatic life events. The DTS scales include measures three symptom clusters: Intrusion, Avoidance/Numbing, and Hyperarousal. The scale is intended to cover all types of trauma including such events as a sexual assault, criminal assault, accident and/or natural disaster. The test-retest reliability was measured using the Pearson correlation coefficient between time one and seven days later at time two was $r = .86$ ($p < .01$). Internal consistency was demonstrated using split half reliability, with a Pearson correlation coefficient of $r = 0.95$ ($p < .01$). Convergent validity studies using the Impact of Events Scale (IES), Trauma Symptom Checklist (TSC) and the Symptom Checklist 90-R ranged from $r = .24$ to $r = 75$ all at the .01 level of probability. Divergent validity was assessed using the Eysenck Personality Inventory since there is no theoretical reason why extraversion would be related to trauma and PTSD. The Pearson correlation coefficient was $r = .04$ and was not significant (Davidson, 1996).

Using the DTS, the variable "trauma" was tested two ways in this study. First as an overall degree of reported traumatic feelings (total trauma score) which reflected the individuals reported degree of current trauma and ranged in score from 0 – 136. Second, the total trauma score consisted of three symptom clusters; Intrusion, Avoidance/Numbing and Hyperarousal, and these subscales were also looked at independently. These clusters reflect criteria B, C and D in the DSM-IV definition of PTSD (APA, 1994; Davidson, 1996).

The Participant Information Questionnaire is a brief, two-page, self-administered questionnaire developed by the author to assess patient demographics and other information deemed important to this research. The questionnaire is similar to those commonly used during an intake procedure and covers such areas as prescription medication currently used, hospitalisations, marital status and level of educational attainment. The questionnaire consists of fill in the blank, multiple choice and yes/no responses.

Procedure

This project involved the use of two different samples, BPD group and a control group. A slightly different procedure was used for each sample. The procedure for each sample is described below.

First, the BPD group was contacted approximately one to two weeks before the expected data collection date and given an Information Letter, which explained the purpose and time commitment of the study, risks and benefits and participant rights. For those women who chose to participate they were given a package containing the instruments utilized for this group. The instruments for this study included a Consent Form, SA-45, ISS, DTS and the Participant Information Questionnaire. All women had previously been given the DIB-R by their psychiatrist upon admission to the aftercare program and had obtained a score of 8 or higher on the instrument. All the participants in the BPD group were tested within the same week at the hospital.

Second, the control group consisted of students from two University undergraduate classes. During a designated class time, the researcher handed out the Information Letter and reviewed it with the class. Those students who chose to participate were given a package containing the following instruments: a Consent Form, SA-45, ISS, DTS, the Participant Information Questionnaire and the Cluster B Personality Scales of the PDQ-4. Both of the undergraduate classes were tested within the same week and in the same building at the University.

All of the participants were treated in a manner consistent with the ethical guidelines set out by both the University of Alberta and the Capital Health Authority. Ethics approval from the University of Alberta Faculties of Education and Extension Research Ethics Board and the University of Alberta Health Sciences Faculties, Capital Health Authority and Caritas Health Group Research Ethics Board (Panel B) was obtained.

Results

To test hypothesis one, correlations were used. The variable "trauma" was found to be normally distributed for the BPD group but not normally distributed for the control group. The control group was skewed to the right or positively skewed. Therefore, a non-parametric correlation, Spearman's rho, was used for the control group while a Pearson correlation was used for the BPD group. The variable "internalized shame" was normally distributed in each of the samples.

The results indicated that for the BPD group internalized shame was significantly positively correlated with the overall degree of trauma, $r\ (36) = .595$, $p < .01$. Similarly, internalized shame and overall degree of trauma were also found to be significantly positively correlated for the control group at $r_s\ (49) = .396$, $p < .01$.

The mean overall trauma score for the BPD group was $M = 85.61$ ($SD = 25.74$) and overall internalized shame score was $M = 64.17$ ($SD = 16.98$). For the control group, the overall trauma score was $M = 26.29$ ($SD = 23.70$) and internalized shame score was $M = 24.29$ ($SD = 14.77$).

A comparison of the relationship between internalized shame and each of the three symptom clusters was made for each group. Each cluster score was transformed into a score that could range from 0 – 40. For the BPD group, the mean subtest scores were as follows: Intrusion *M* = 24.42 (*SD* = 10.44); Avoidance/Numbing *M* = 23.97 (*SD* = 8.20); Hyperarousal *M* = 27.42 (*SD* = 9.32). The control group had the following means: Intrusion *M* = 9.25 (*SD* = 7.93); Avoidance/Numbing *M* = 5.78 (*SD* = 7.53); Hyperarousal *M* = 8.96 (*SD* = 8.99).

Correlations were made between internalized shame and each of the symptom clusters. As displayed in Table 3-1, the subscales of Avoidance/Numbing and Hyperarousal were significantly correlated with internalized shame for both the BPD and control groups. Intrusion was not found to be significantly correlated at the .01 level of probability for either of the groups.

Table 3-1

Correlations between Internalized Shame and the Three Trauma Symptom Clusters

Group	Intrusion	Avoidance/ Numbing	Hyperarousal
BPD			
Internalized Shame	.35	.44*	.63*
Control			
Internalized Shame	.18	.48*	.39*

* $p < .01$

Overall, hypothesis one was supported – a higher degree of trauma is correlated with higher internalized shame in both the BPD group and the control group. However, it must be noted that when the overall trauma score was broken down into the three symptom clusters, the Intrusion subtest was not significantly correlated with internalized shame for either of the groups.

The second hypothesis, examining the variables of trauma and psychiatric symptomatology also used correlations. Again, the variable of "trauma" was not normally distributed in the control group so Spearman's rho was used while Pearson correlation was used for the BPD group. The variable of psychiatric symptomatology was found to be normally distributed for both groups. Descriptive statistics for both groups include a mean trauma score of $M = 85.61$ ($SD = 25.74$) for the BPD group and $M = 26.29$ ($SD = 23.70$) for the control group. For the overall measure of psychiatric symptomatology (GSI), the BPD group had an $M = 73.28$ ($SD = 8.45$) and the control group had an $M = 56.53$ ($SD = 7.47$). Descriptive statistics for all the measures of psychiatric symptomatology can be found in Table 3-2. The BPD group scored significantly higher on all measures of psychiatric symptomatology at the .01 level as tested using an independent samples t-test.

Table 3-2

Psychiatric Symptomatology Reported by the BPD and Control Groups

Scale	Group	*M*	*SD*	*t*
GSI				
	BPD	73.28	8.45	9.66*
	Control	56.53	7.47	
PST				
	BPD	72.47	7.63	8.75*
	Control	58.31	7.19	
Anxiety				
	BPD	74.22	6.48	10.37*
	Control	57.14	8.17	
Depression				
	BPD	71.14	7.39	9.46*
	Control	56.96	6.39	
Hostility				
	BPD	68.06	7.69	6.88*
	Control	58.04	5.74	
Interpersonal Sensitivity				
	BPD	68.61	7.73	7.35*
	Control	57.65	6.01	
Obsessive-Compulsive				
	BPD	73.69	9.52	8.02*
	Control	58.10	8.33	
Paranoid Ideation				
	BPD	65.67	9.31	5.72*
	Control	54.86	8.05	
Phobic Anxiety				
	BPD	72.00	7.53	7.62*
	Control	61.65	4.99	
Psychoticism				
	BPD	69.56	9.17	4.92*
	Control	61.47	4.23	
Somatization				
	BPD	68.72	9.98	6.91*
	Control	55.53	6.59	

* p< .01.

The results for the two groups indicated that overall degree of trauma and psychiatric symptomatology were significantly positively correlated. For the BPD group, the correlation was r (36) = .760, p < .01 and for the control group the correlation was r_s (49) = .580, $p < .01$.

When the three symptom clusters were correlated with psychiatric symptomatology for both groups all were significant at the .01 level of probability except for the Intrusion subscale for the control group (r_s (49) = .363, $p = ns$). The correlations for the BPD group were all significant at the .01 level. They were: Intrusion $r = .482$, Avoidance/Numbing $r = .758$; Hyperarousal $r = .636$. For the control group, Avoidance/Numbing and Hyperarousal subscales were significant at the .01 level and the results were $r_s = .589$ and $r_s = .539$ respectively.

Overall, hypothesis two was supported - a higher degree of trauma was positively correlated with psychiatric symptomatology in both the BPD group and the control group. One exception to this was the symptom cluster, Intrusion, for the control group was not statistically significant at the .01 level.

An independent samples t-test was used to test the third hypothesis, that the BPD group would report a higher degree of trauma than the control group. Since the data came from a markedly non-normally distributed population, the Mann-Whitney was used instead of a standard t-test. The Mann-Whitney is typically used as the non parametric equivalent for the two sample t-test (SPSS Inc., 1999). This test compares the center of location for the 2 samples by ranking the data. The disadvantage of the Mann-Whitney is it requires a larger sample size to detect differences between groups than the t-test.

The Mean Rank for the BPD group ($n = 36$) was 64.61 while the Mean Rank for the control group ($n = 49$) was 27.05. The value of the Mann-Whitney U statistic was 100.5 with a $z = -6.953$, which was significant at the .001 level. Thus, we rejected the null hypothesis that the trauma scores are equal for the BPD and control groups. The third hypothesis was supported because the BPD group reported a significantly higher degree of trauma than the control group.

Initially, hypothesis four (comparing the reported trauma of those who were sexually abused with those who were not) was going to use both the BPD group and the control group. However, the number of individuals reporting sexual abuse in the control group was too small ($n = 5$). Further, Levene's test for equality of variance was significant ($F = 4.675$, $p = .036$) indicating that the assumption of homogeneity of variance was not met so the original plan to perform a 2x2 ANOVA was no longer viable. Therefore, the testing of this hypothesis could only be completed using the BPD group.

It is important to note that the trauma score could range from zero to 136. The mean score for the BPD group was 84.64 for those who reported sexual abuse and 86.23 for those reporting a trauma other than sexual abuse. Fourteen women in the BPD group (39%) reported sexual abuse (see Table 3-3).

Table 3-3

A Comparison of the BPD and Control Group Trauma Scores by Trauma Type

Group	Number Reporting the Trauma	Trauma Type	Mean Trauma Score	Standard Deviation
BPD	14	Sexual Abuse	84.64	7.82
	22	Other	86.23	5.11
Control	5	Sexual Abuse	24.60	3.19
	44	Other	26.48	3.76

As noted in Table 3-4 there was a variety of different responses to the question "please identify the trauma that is most distressing to you" (Davidson, 1996). Many of the women reported a trauma other than the ones listed in the table and were included in the category "other". This category included all types of trauma, other than sexual abuse, that was listed by only one of the participants. These traumas are not reported here as it may compromise the individuals right to confidentiality. It is feasible that a person's identity could be established if specific events were listed in this study. Therefore, it was decided that these traumas would be placed in a category deemed "Other". Also of interest is the category "No Trauma Reported" in which 10% of the control group was included and none of the BPD group. During the study, these women wrote on their testing instruments that they did not believe that they had suffered any traumatic event in their life.

Table 3-4

Frequency of the Different Traumas Reported by the BPD and the Control Groups

Trauma Reported	BPD Group (%)	Control Group (%)
Sexual Abuse	38.9	10.2
Death/Injury/Illness of Family or Friend	2.8	26.5
Family or Relationship Problem	11.1	16.3
Car Accident	2.8	6.1
Other	44.4	30.6
"No Trauma" Reported	0	10.2

To assess whether the reported degrees of trauma differed within the BPD group, the women were divided into two groups, those who listed sexual abuse as their traumatic event ($n = 14$) and those who listed something other than sexual abuse ($n = 22$). Equal variances could be assumed according to Levene's test for equality of variances ($F = 796$, $p = .378$). To compare the means of the two groups of BPD women on the overall measure of trauma and on each of the three trauma subscales, a one-way ANOVA was used. The results indicate that the BPD group reporting sexual abuse and the BPD group reporting another type of traumatic event were not significantly different in degree of trauma reported [(F (1, 34) = .03, p = .86)]. No significant differences between the two groups were found on the trauma subscales of Intrusion [(*F* (1, 34) = .02, *p* = .89)], Avoidance/Numbing [(*F* (1, 34) = 1.65, *p* = .21)], and Hyperarousal [(*F* (1, 34) = .44, *p* = .51)].

Overall, hypothesis four was supported for the BPD group – there were no significant differences in trauma reported for those who were sexually abused compared to those who did not list abuse. However, the small number of women reporting sexual abuse in the control group made statistical analysis inappropriate.

Discussion

In this study, the focus was on investigating how trauma and internalized shame were related and, in turn, influenced an individual's level of functioning (psychiatric symptomatology). Not surprisingly, when comparisons between an outpatient group of women diagnosed with BPD were compared to a University sample of women, significant differences were found between the two groups. Specifically, the BPD group reported significantly higher degrees of trauma, internalized shame and psychiatric symptomatology. While the University women scored in the "not clinical" and "low" ranges on the testing instruments, the BPD women scored "clinically significant" and "high". This suggests that, as a group, the BPD women were functioning at a lower level and had a great deal of emotional and/or psychological difficulties that needed to be addressed. This may not seem surprising when one considers the volatile and emotionally labile behaviours often associated with this population, however, it warrants mentioning again that this is an outpatient group. While they have been discharged from the hospital and are not considered a danger to themselves or others, clearly they are still struggling with many issues that make functioning effectively in society difficult. Thus, this discussion focuses on the BPD group in hopes to try to understand more about this population.

When examining the relationship between trauma and internalized shame it was found that the two are significantly positively correlated. This means that the higher the individual's reported degree of trauma the more internalized shame was also reported. This relationship makes theoretical sense when we consider the definition of internalized shame as including such feelings as being incompetent, inferior and hopeless (Cook, 2001). Those who have been traumatized report similar reactions. Thus, the traumatic event may serve to reinforce and magnify a BPD woman's sense of internalized shame.

The three symptom clusters usually associated with trauma - Intrusion, Avoidance/Numbing and Hyperarousal - were also each examined independently to ascertain their relationship with internalized shame. Avoidance/Numbing and Hyperarousal were both significantly correlated with internalized shame. Avoidance/Numbing refers to the persistent avoidance of stimuli associated with the trauma while Hyperarousal refers to persistent symptoms of increased arousal (not present before the trauma) such as hypervigilance and exaggerated startle response. Interestingly, the symptom cluster of Intrusion was not significantly correlated with internalized shame. Intrusion refers to having the traumatic event persistently re-experienced through such things as distressing dreams or dissociative flashback episodes (APA, 2000).

There are three possible reasons for the lack of a relationship between internalized shame and the symptom of Intrusion. First, it is possible that the BPD women have had successful therapy and that the debilitating aspect of "reliving" the trauma has been suppressed. It is often argued that the lingering impact of trauma, its intrusiveness and persistence, bring people to psychotherapy. They seek relief, resolution and better management of the activation and freezing responses triggered by memories and reenactments of trauma (Goetz, 2001). Thus, it may be that the women in this study have successfully dealt with this aspect of the trauma while their other trauma symptoms are still persistent. Second, researchers (Green, Krupmick, & Stockton, 2001) have found that the Intrusion symptoms occur more when the trauma is related to a loss (e.g., death of a family member or friend) rather than to other types of trauma (e.g., abuse). When examining the traumas reported by the BPD women, only 2.8% of the women reported death of family member or friend as their traumatic event. The current study may lend some support to this hypothesis, however, the very small number of women reporting a loss makes generalizing difficult. Third, according to the theory of internalized shame, the emotion can either be accepted and therefore the person develops a new sense of self or the person continues to defend against the pain of shame (Cook, 2001; Nathanson, 1992; Nathanson, 1996). After an easily defined trigger occurs (e.g., an intrusive thought about the trauma) the person has a choice about how to respond to the shame associated with the trigger. Most people with high internalized shame, like the BPD women, respond by behaving in destructive ways to alleviate this painful affect. Some of the behaviours include exhibiting anger, attacking self, attacking others or withdrawing. Indeed, the borderline is noted as oscillating between attacking self and attacking others to defend against shame (Millon, 1987 as cited in Cook, 2001). It is this theory that is supported in this research. Therefore, the next step was to examine the common maladaptive reactions or symptoms that the BPD women may have or use to avoid this painful emotion. The relationship between internalized shame and psychiatric symptomatology was examined.

Some of the symptoms reported within the BPD population include feelings of dysphoria, anxiety and isolation (APA, 2000). This study examined such feelings by utilizing the SA-45, which is a well-researched measure of psychiatric symptomatology. Psychiatric symptomatology is also referred to as level of functioning and includes measures of anxiety, somatization, hostility and depression. A high level of psychiatric symptomatology refers to a low level of functioning. It was found that BPD women reporting the highest degree of trauma also reported in the clinically significant range in all measures of psychiatric symptomatology. The strong relationship between degree of trauma and psychiatric symptomatology supports other researchers (e.g., Margo & McLees, 1991) who also found that women with trauma histories had high scores on the SCL-90 (a measure of symptomatology).

However, it is debated in the literature whether one traumatic event can cause more psychological and/or emotional damage than another can. Of particular interest in the BPD population is the issue of sexual abuse. Some have argued that sexual abuse is a strong predictor in the development of BPD (Kroll, 1993), and it is this trauma that is the origin of the many challenging behaviours seen in this population. Others argue that trauma, regardless of the type, intensify the symptoms of BPD (e.g., Paris, 1994). It is not about the type of trauma per se but it is the individual's emotional reaction to it.

To try to address this issue, the current study compared the degree of trauma reported by BPD women who were sexually abused to those BPD women who experienced a trauma other than sexual abuse. No significant differences were noted between the two groups on overall degree of trauma as well as on the three symptom clusters (Intrusion, Avoidance/Numbing and Hyperarousal). While it is premature to assert that sexual abuse has the same overall effect as other traumas (e.g., car accidents, death of family member) this research supports the idea that it may be more about the woman's response to the trauma then the event itself.

Conclusion and Future Direction

In summary, this study lends support to the literature purporting that women in the BPD population have a significant level of psychiatric symptomatology and internalized shame. While this may not be surprising, this study offered a unique look at how internalized shame and traumatic events may combine to exacerbate and maintain their symptoms. It appears these women have high levels of internalized shame and this knowledge, in terms of a practical interpretation of these findings, benefits those working with this population. Specifically, shame has been reported to interfere with the therapeutic process and oftentimes shame is not expressed in a manner in which the therapist can understand. It is important for the therapist to respond "with validation as opposed to censure, with acceptance rather than rejection. In particular, the therapist should be alert to the fact that disclosing the shameful events is itself shaming" (Linehan, 1993, p.349). When a BPD woman stalls or sabotages her progress in treatment it may be that she is employing her well used coping strategies (i.e., attacking self) to guard against the painful feelings of internalized shame.

This study also supported the argument that the type of traumatic event experienced by the BPD woman may not be a major determinant in their level of psychiatric symptomatology or internalized shame. No significant differences were found between women reporting sexual abuse and those who reported a trauma other than sexual abuse. This population is often regarded as having difficulty maintaining and regulating their emotions and as such, it may be more about the individual's response to the trauma than the trauma itself.

When looking ahead to the future, there are two main questions left unanswered by the current study. The first is the question of age of the traumatic event. In this study, the participants did not record the age in which their traumatic event occurred. While it is unlikely that all the reported occurrences of sexual abuse in the BPD population occurred as adults, it is impossible to conclude that the abuse only occurred during childhood. Thus, to support or refute the current findings, that the traumatic event is more about the individual's reaction rather than the type of event, a study in which the participant's age at time of trauma is recorded would be beneficial.

Second, it would be valuable to understand how treatment (e.g., therapy) and/or support affect the woman's level of psychiatric symptomatology. As noted, both internalized shame and trauma induce feelings of hopelessness (Cook, 2001) worthlessness and fear. Possible research questions may include: does having a supportive social network or therapeutic alliance help alleviate the intensity of the negative feelings? What type of therapy works best in reducing internalized shame in this population? The ability to understand both the underlying emotional reasons for the BPD women's behaviour as well as the efficacy of different treatments would be the ultimate goal of such research.

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CHAPTER 4

SOCIAL SUPPORT AND BORDERLINE PERSONALITY DISORDER: THE NEGATIVE IMPACT OF POOR SOCIAL PROBLEM-SOLVING SKILLS AND SHAME

Purpose

The focus of this paper is on the relationship between internalized shame, social problem-solving skills and social support in women diagnosed with Borderline Personality Disorder (BPD). It has been argued that individuals with BPD derive particular benefit from dependable, positive relationships (Linehan, 1993). The difficulty here is that the woman diagnosed with BPD tends to be consistently unable to sustain and maintain a positive relationship in part because of a lack of effective social problem-solving skills. To further complicate things, research indicates that shame may impede problem-solving because the action tendency of shame runs counter to effective problem-solving (Rizvi & Linehan, 2002). It is the goal of this study to better understand how shame and social problem-solving interact and to determine how they influence the borderline's ability to maintain and sustain a healthy social network.

Review of the Literature

The diagnostic features of BPD include frantic efforts to avoid abandonment and a history of unstable and intense relationships (American Psychiatric Association (APA), 2000). Women with BPD often describe feelings of loneliness, emptiness and rejection. The difficulty for these women is that while they crave the support and nurturance of others, they often behave in ways that elicit rejection rather than acceptance.

A popular theory of the development of BPD has been developed by Marsha Linehan (1991). Her theory includes both a biological susceptibility and environmental factors. Linehan (1993) considers the biological risk factor as "emotional vulnerability". She describes this as being excessively sensitive to emotional input and having intense and protracted reactions to even low levels of stimulation. She suggests that if a person is born with a high emotional vulnerability and has poor emotional regulation (e.g., cries easily) this leads to emotional dysfunction. However, if this emotional dysfunction is also coupled with an invalidating environment (e.g., abuse) the combination leads to emotional instability. Therefore, in this view, BPD is a disorder of emotional instability at its core.

Her theory on the criteria of BPD remains consistent with the criteria put forth in the Diagnostic and Statistical Manual – Fourth Edition (DSM-IV; APA, 1994). While Linehan has not redefined the DSM-IV criteria, she has reorganized it somewhat. Her reorganization was made to put emphasis on the features that she found to be most intrusive and common in the borderline population and to group together criteria she found to be conceptually and behaviourally related.

Linehan's first category is titled emotional dysregulation. Her major premise is that BPD is:

> primarily a dysfunction of the emotion regulation system; it results from biological irregularities combined with certain dysfunctional environments,

> as well as their interaction and transaction over time. The characteristics associated with BPD are sequalae of, and thus secondary to, this fundamental emotion dysregulation. (Linehan, 1993, p.43)

This category is marked by emotional instability (e.g., reactivity of mood, such as shame, anxiety) and problems with anger. This category, emotional dysregulation, is considered to include the defining features of BPD for Linehan. It is proposed in her theory that emotional dysfunction plus an invalidating environment leads to emotional instability. Thus, the inability to successfully regulate and control (stabilize) emotions is seen as the key diagnostic criteria.

Linehan's second category is interpersonal dysregulation, which is categorized by relationships that are chaotic, intense and marked with difficulties. This category is consistent with the DSM-IV's Criterion 1 (frantic efforts to avoid real or imagined abandonment) and Criterion 2 (a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation) (APA, 2000). As Linehan (1993) states "in (her) experience, borderline individuals, more so than most, seem to do well when in stable, positive relationships and to do poorly when not in such relationships" (p. 11).

The third category, behaviour dysregulation, consists of the pattern of extreme and impulsive behaviours frequently engaged in by individuals with BPD. These behaviours include such things as suicide attempts, self-mutilation, substance abuse and binge eating. Cognitive dysregulation, the fourth category, is marked by brief, nonpsychotic forms of thought dysregulation, including depersonalization and delusions. Lastly, self dysfunction refers to the BPD individuals unstable self; for instance, dramatic, sudden switching of goals and values or an almost complete change of self depending who the person is with at a given time. A chronic feeling of emptiness is also a feature of this category.

In summary, Linehan suggests that the main difficulties for those with BPD are the ability to regulate negative emotions and their involvement in chaotic interpersonal relationships. A negative emotion that many researchers view as playing a central role is that of shame. In the following section, the emotion of shame is discussed.

Shame

The emotion of shame is often confused with that of guilt. Middleton-Moz (1990) offers the following points to clarify the difference between the two emotions:

> 1. When we experience guilt, we may fear punishment but when we are punished or have made amends the guilt is resolved. When we experience shame, we fear abandonment.
> 2. We often feel ashamed of our shame. Although we may fear punishment, there is usually relief in confessing guilt. The fear of further abandonment however, often prevents the expression of shameful experiences or even the conscious awareness of shameful feelings. (pp. 55-56)

Shame, as with all human emotion, can range from a transitory affect that is easily managed to a consistent and persistent mood that becomes an inflexible, unchanging and pervasive part of the personality. The concept of *internalized shame* depicts an extreme and intense sense of shame as a core chronic aspect of identity, as distinct from the emotion of shame, which although sometimes intense, is transitory (Balcom, Call & Pearlman, 2000). Internalized shame permeates a person's life as the filter through which all experience is perceived (Spero, 1984; Thrane, 1979). Shame gives one a sense of worthlessness, the feeling of being isolated, empty, and alone in a complete sense.

Viewing shame as an "intense, negative affect . . . internalized into one's sense of self," it becomes possible to explain the puzzling and hard-to-change cluster of symptoms of BPD as the expression of and defense against the painful emotion of shame (Cook, 2001, p. 1). It is proposed that the phases of shame are experienced as a involving a (1) Triggering Source (2) Physiological Phase (3) Cognitive Phase (4) Decision Phase and (5) Reactive Phase (Cook, 2001, p. 28).

The Triggering source is an easily defined stimulus that interrupts positive affect (i.e., joy, contentment). It can involve a newly experienced stimulus (i.e., an employee is fired by her boss in front of her coworkers) or a deeply ingrained, learned stimulus that is easily brought to the surface. For example, a woman is ridiculed as a child and is hypersensitive as an adult to indications from others that she is not accepted. The Physiological Phase refers to the physical sensation of shame. For example, the slump of the head, down-caste eyes or a "momentary lapse in our ability to think (referred to as "cognitive shock")" (Nathanson, 1992, Nathanson, 1996, as adapted by Cook, 2001, p. 28). The Cognitive Phase refers to the process of trying to think about, organize and understand the situation. In the Decision Phase, the individual decides how to respond to the situation. Finally, the Reactive Phase is the reaction to the feeling of shame. The Reactive Phase consists of four different actions of the person who is shamed. Briefly, the four styles are:

Withdrawal: using this reaction to shame, the person turns away from the offending stimulus, hides, runs away or will grow quiet in a therapy session. Withdrawal tends to present as depression and sadness.

Attack Self: those who most fear the sense of abandonment that can accompany unexpected shame often engage in the intentional derogation of the self, a situation that can be described as "trading loneliness for a dangerous safety". Attack Self tends to present as self-directed anger, masochistic traits and helplessness.

Avoidance: this is the response of those who will try to do almost anything to avoid the feeling of shame. Typical avoidance strategies include the abuse of alcohol or drugs and to engage in behaviour that distracts attention from what might bring shame.

Attack Other: those who experience shame as a moment of terrible inferiority and can only feel better by reducing the self-worth of someone else, take this action. It is an attack mode of self-defence and typically presents as anger and antisocial personality styles. (Nathanson, 1993, as adapted by Cook, 2001, pp. 27-31).

Linehan distinguishes between shame and guilt in a manner consistent with Nathanson (1992). Namely, both theorists see shame (or as Nathanson would state "internalized shame") as a condition of disgrace and an intense negative affect internalized into one's sense of self. Shame is about the failure of the self. Conversely, guilt is described by both as a failure to live-up to some outside standard or rule. Internalized shame would be expected to have a far-reaching, negative impact on the lives of women with BPD. As mentioned, the reaction of a person to feelings of shame can include such maladaptive coping styles as withdrawal or avoidance. It is possible that BPD's react to shame in the same way that they react to other problems. For example, if an individual uses the withdrawal response to shame, she may also retreat and become depressed after a minor argument with a friend thus deepening her sense of isolation. In this way, the woman's reaction creates more difficulties for her.

Social Problem-Solving

One of the hypothesized difficulties in helping women with BPD is that they lack problem-solving strategies (Linehan, 1993). This deficit in the ability to handle minor everyday stresses and problems is especially noticeable in the BPD's response to interpersonal difficulties and inability to cope with problems without becoming emotionally unstable. This inability to cope with everyday problems is seen as an obstacle in treating an individual with BPD.

According to contemporary models of social problem-solving (D'Zurilla & Goldfried, 1971; D'Zurilla & Nezu, 1990; Nezu & D'Zurilla, 1989), people's orientations to their problems determine the manner in which they process information about themselves, the environment, and problematic situations encountered in everyday life. Problem orientation, or attitude toward problem-solving, involves the ability to (a) ward off negative emotions (e.g., anxiety, depression, shame) that hamper problem-solving efforts, (b) promote positive emotions and a sense of competency that facilitate problem-solving, and (c) motivate an individual toward solving problems (D'Zurilla & Nezu, 1990; D'Zurilla & Sheedy, 1991; Nezu & D'Zurilla, 1989).

Persons with a Positive Problem Orientation (PPO) often resolve everyday problems without much effort, preventing these problems from exacerbating. Consequently, a sense of competency and self-efficacy is reinforced as the individual recalls these successful experiences when problems that are more complex are encountered. In contrast, a Negative Problem-solving Orientation (NPO) is associated with ineffectual coping, negative emotional experiences under general and stressful conditions, and more critical views of the self and personal abilities (Elliott, Herrick, MacNair, & Harkins, 1994; Elliott, Sherwin, Harkins, & Marmarosh, 1995), which tend to reinforce a negative orientation and impair problem-solving efforts (Nezu & D'Zurilla, 1989).

D'Zurilla, Nezu and Maydeu-Olivares (2002) make a distinction between a person's problem orientation and their problem-solving style. Whereas problem orientation is primarily a motivational process involving the operation of relatively stable cognitive and emotional strategies that reflect the thoughts and feelings of a person concerning his or her problems in living as well as his or her own problem-solving ability, a person's problem-solving style is slightly different. Problem-solving style refers to the overt behavioural activities the person engages in when finding a solution. D'Zurilla et al., (2002) have developed three styles that correspond to the person's problem orientation. First, rational problem solving (RPS) is a "constructive problem-solving style that is defined as the rational, deliberate, systematic, and skilful application of effective or adaptive problem-solving principles and techniques" (D'Zurilla, et al., 2002, p. 4). The impulsive/careless style (ICS) is considered a dysfunctional approach in which the person attempts to solve a problem but the attempts are impulsive, narrow and incomplete. Lastly, the avoidance style (AS) is another dysfunctional approach and is characterized by procrastination, passivity or inaction, and dependency. The rational problem solving is strongly related to having a positive problem orientation, while the impulsive/careless and avoidance styles are related to having a negative problem orientation (D'Zurilla, Chang, Nottingham, & Faccini, 1998).

To summarise, social problem-solving abilities play a pivotal role in the way a person processes information about the self, the environment, and the problems encountered in everyday life.

Social Problem-Solving and Borderline Personality Disorder

Research by Douglass (2000) on the problem-solving ability of women with BPD indicates that these women tend to demonstrate overall poor problem-solving ability, including avoiding problems. These women also tend to express feelings that they have little control in problem-solving tasks when compared to normative samples. Further, those with BPD are more likely to view problems as a threat to their well-being and depend on others to solve their problems. This lack of effective problem-solving is compounded if the person also has a high level of internalized shame (Cook, 2001). A person suffering from internalized shame is typically prone to misread social cues and communication, to expect the worst in all situations, and to see abuse and injury in benign social exchanges.

Researchers (Kanter, Parker & Kohlenberg, 2001) found that persons with BPD suffered from the excessive influence of other people and that their sense of self was controlled by the actions and reactions of others. The BPD individual has a tendency to implement skills in an impulsive manner or not at all, waiting for problems to solve themselves.

Linehan's Theory and Social Problem-Solving

Linehan views problem-solving strategies as core to her theory of BPD and her treatment method, Dialectic Behaviour Therapy (DBT). She has a comprehensive strategy in place for helping women with BPD develop effective problem-solving skills (Linehan, 1993). Indeed, much of DBT rests on teaching the participants how to handle problems, from resisting impulsive negative behaviours, such as parasuicide, to understanding effective communication and relationship management. For Linehan, the individual with BPD has "learned" negative or harmful ways of dealing with crisis and problems from growing up in an invalidating environment. This lack of knowledge about how to effectively solve problems coupled with emotional dysregulation tends to push the individual into crisis when confronted with a difficulty.

Linehan describes the BPD response to problems in a similar way to that described by Douglass (2000) and D'Zurilla, et al., (2002). Specifically, that those with BPD have a negative problem-solving orientation and tend to utilise "active passivity". She describes this problem-solving style as the "tendency to passive interpersonal problem-solving style, involving failure to engage actively in solving of own life problems, often together with active attempts to solicit problem-solving from others in the environment; learned helplessness, hopelessness" (Linehan, 1993, p.10). Linehan's description of the typical BPD response is consistent with that described as the "avoidance style" (D'Zurilla, et al., 2002).

Goal of the Current Research

The focus of this paper is on the relationship between internalized shame, social problem-solving skills and social support. The basis of this paper rests with Linehan's theory, specifically, her discussion of Interpersonal Dysregulation, and the corresponding Criteria 1 and Criteria 2 from the DSM-IV-TR (re: frantic efforts to avoid real or imagined abandonment and a pattern of unstable and intense interpersonal relationships). As stated earlier, an individual's inability to effectively problem-solve creates negative consequences in the quality of her life (D'Zurilla, et al., 2002). Specifically, the BPD is consistently unable to sustain and maintain positive relationships due to a severe lack of effective social problem-solving. Research indicates that shame may further impede problem-solving because the action tendency of shame runs counter to effective problem-solving (Rizvi & Linehan, 2002). This has led Linehan (1993) to hypothesise that the "BPD reaction to shame is the use of hiding" (p. 355), which is consistent with research (Douglass, 2000) suggesting that the BPD individuals generally rely on either the avoidance style or withdrawal style of social problem-solving.

To understand the relationship between the factors of internalized shame, social problem-solving and social support this study will compare two groups, a clinical group of women diagnosed with BPD and a control group made up of university students. The experiment consists of four hypotheses and one research question. They are: Hypothesis

One: The control group will have more effective social problem-solving skills than the BPD group. Hypothesis Two: In both groups, there will be a negative relationship between internalized shame and effective social problem-solving skills. Hypothesis Three: The BPD group will score higher on the avoidance style of social problem-solving. Hypothesis Four: The control group will have more social support than the BPD group. Research Question One: Do any of the variables (internalized shame, social support and/or social problem-solving) effectively differentiate between the control group and the BPD group?

Method

Participants

This study used two samples. The first consisted of adult women diagnosed with BPD (*n* = 36). These women were outpatients involved in an aftercare program at an Alberta hospital. Each woman had the primary diagnoses of BPD as determined by a psychiatrist and, in addition, obtained a score of 8 or higher on the Diagnostic Interview for Borderlines – Revised (DIB-R) (Zanarini, Gunderson, Franckenburg & Chauncey, 1989). The control group consisted of adult women enrolled in an undergraduate course at an Alberta university. None of these women had ever had the diagnoses of BPD. This was ascertained by asking the women about their medical and hospitalization history as well as using the Cluster B section of the Personality Diagnostic Questionnaire – 4 (PDQ-4) (Hyler, 1998). Those women who scored in the clinically significant range on the PDQ-4 or admitted hospitalizations/medications for symptoms associated with BPD were not included in this study. Overall, two women from the control group (3.9%) were excluded while none of the BPD women were excluded.

There were four additional criteria that could exclude a person from participating in this study. First, the study consisted only of adult females. Males and those under the age of 18 were not included. Second, a current diagnosis of schizophrenia or other psychotic disorder excluded the individual. Lastly, because of the recommended reading level of the instruments used, those with less than a grade 8 education could not participate.

Participant Characteristics

The ages for the BPD group ranged from 19-59 ($M = 35.11$, $SD = 11.05$) and 20-54 for the control group ($M = 29.39$, $SD = 8.62$). The ethnic/cultural background reported for the two groups were similar. The majority of the women in the BPD and control group were Caucasian, 91.7% and 89.8% respectively. The next highly endorsed ethnic/cultural group was Native/Metis (5.6%) for the BPD group and Asian (4.1%) for the control group. The remaining participants reported falling in the category "Other".

Medication use differed between the two groups as expected. All of the women in the BPD group reported taking prescription medication. The most commonly reported medications included antidepressants, antipsychotics, hypnotics, anticonvulsants, anxiolytics and birth control pills. Forty-five percent of the women in the control group reported taking prescription medications. The most commonly reported medications included birth control pills and antidepressants.

In terms of employment, only 16.7% of the BPD group reported working while 51.0% of the control group was employed. Differences in yearly income was also noted with 50.0% of the BPD women reporting less than $30,000, compared to 38.3% of the control group.

The BPD group reported their current relationship status as single (47.2%), married/common-law (38.9%) and divorced/separated (13.9%). The women in the control group described their current relationship as single (57.1%), married/common-law (40.8%) and divorced/separated (2.1%). Currently, 19.4% of the BPD group report living alone compared to 4.1% of the control group.

Measures

This study utilised six different testing instruments. These included the Diagnostic Interview for Borderlines – Revised (DIB-R), The Personality Diagnostic Questionnaire (PDQ-4), Internalized Shame Scale (ISS), Interpersonal Support Evaluation List-12 (ISEL-12), Social Problem Solving Inventory - Revised (SPSI-R) and the Participant Information Questionnaire. The six instruments are described in some detail below.

The Diagnostic Interview for Borderlines –Revised (DIB-R) was developed as a tool to aid in the diagnosis of BPD (Zanarini, et. al., 1989). It considers symptoms that fall under four main headings: Affect (i.e., emptiness, worthlessness), Cognition (i.e., nondelusional paranoia), Impulse Action Patterns (i.e., manipulative suicide gestures, substance abuse) and Interpersonal Relationships (i.e., devaluation, demandingness). Inter-rater and test-retest reliabilities indicate kappa's greater than .75 in the diagnosis of BPD. When examining the different symptoms, one-third of the BPD symptoms assessed had a kappa's over .75 and the remaining two-thirds had a fair to good kappa scores (.57-.73) (Zanarini, Frankenburg, & Vujanovic, 2002).

The Personality Diagnostic Questionnaire – 4th Edition (PDQ-4) is a 100 item, self-administered, true/false questionnaire that yields personality diagnoses consistent with the DSM-IV diagnostic criteria for axis II disorders (Hyler, 1998). The PDQ-4 consists of two validity scales. The Too Good scale is designed to pick up under-reporting while the Suspect Questionnaire scale is designed to identify individuals who are either lying or are responding randomly. Internal consistency measures are acceptable and fall in alphas of .70 (Wilberg, Dammen & Friis, 2000). The measure has demonstrated good specificity and sensitivity, but does have a relatively high false positive rate, especially for the Histrionic scale (Lyoo, Youn, Ha, Park & Kwon, 2003; Wilberg et al., 2000).

The Internalized Shame Scale (ISS) (Cook, 2001) is a 30-item self-report Likert-type scale composed of 24 items that measure shame and six items that measure self-esteem. The six self-esteem items are an adaptation of the 10-item Rosenberg Self-Esteem Scale (Rosenberg, 1965). The internal consistencies for item-total correlations were reported at alpha's ranging from .52 to .82 with a median correlation of .70. The alpha reliability coefficient of .96 indicates the items are very high in internal consistency. Convergent validity was tested using the Rosenberg Self-Esteem scale and the total score from the Tennessee Self-Concept Scale. The correlations between the shame scale and the self-esteem scales were r = -. 90 and r = -. 66 respectively. Further, the ISS was correlated with numerous measures of psychopathology. These measures included the SCL-50 (r = .77), the Beck Depression Inventory (r = .62 to r = .79 depending on the sample) and the Suicide Probability Scale (r = .52 to r = .81 depending on the subtest). Convergent validity correlations ranged from .45 to .74 when comparing the ISS to psychopathology variables obtained from the Brief Symptom Checklist.

The Interpersonal Support Evaluation List - 12 (ISEL-12) is a shorted version of the ISEL-40 (Cohen, Mermelstein, Kamarck, & Hoberman, 1985) and consists of 12 statements designed to assess the perceived availability of three separate functions of social support as well as providing an overall support measure. The three subscales include: the *Appraisal* subscale looks at the perceived availability of someone to talk to about one's problems; the *Belonging* subscale examines the respondents perceived availability of people she can do things with; and the *Tangible* subscale is intended to measure perceived availability of material aid. The ISEL has acceptable psychometric properties, with reliability coefficients ranging from .62 to .86, test-retest correlations between .77-.86 and internal alpha estimates of .88-.90 (Bates & Toro, 1999).

The Social Problem Solving Inventory-Revised (SPSI-R; D'Zurilla, Nezu, & Maydeu-Olivares, 2002) is a 52-item, self-report measure of social problem-solving abilities. The SPSI-R has five scales. Two of the scales measure problem orientation dimensions: Positive Problem Orientation (PPO) and Negative Problem Orientation (NPO). The *PPO* assesses a general cognitive set, which includes the tendency to view problems in a positive light, to see them as challenges rather than threats, and to be optimistic regarding the existence of a solution and one's ability to detect and implement effective solutions. The *NPO* assesses a cognitive-emotional set that hinders effective problem solving. Individuals with a high score on this scale are more likely to view a problem as being a significant threat to their well-being, doubt their ability to solve problems and have a low frustration tolerance (D'Zurilla, et al., 2002, p. 31).

The remaining three scales are considered problem-solving skills scales. The *Rational Problem Solving Scale (RPS)* assesses the tendency to use effective problem-solving techniques systematically and deliberately. This scale assesses both the knowledge a person possesses about effective problem-solving and their ability to implement this knowledge when faced with a problem. *The Impulsivity/Careless Style Scale (ICS)* measures a tendency to implement skills in an impulsive, incomplete, and haphazard manner. A high score on this scale indicates that the individual functions ineffectively in situations requiring problem-solving skills. The *Avoidance Style Scale (AS)* scale assesses dysfunctional patterns characterized by putting the problem off and waiting for the problems to solve themselves.

The internal consistency estimates are as follows: PPO (.76), NPO (.91), RPS (.92), ICS (.83) and AS (.88). The overall internal consistency (alpha) for the SPSI-R was .95. All of the SPSI-R scales, except RPS were significantly correlated with different distress measures (i.e., Symptom Checklist 90 – Revised; Beck Depression Inventory; Suicide Probability Scale) in the expected direction. Some of the significant correlations were .17 (Suicidality), .68 (Anxiety) and -.36 (Hopelessness). According to D'Zurilla, et al., (2002), the "NPO is consistently the best predictor across the different distress measures" (p. 59). Conversely, in a study examining social skills it was found that all the SPSI-R scales were significant (Greensham & Elliot, 1990). For example, the PPO scale was significantly positively correlated (.33) to positive social skills.

To test the structural validity, indices of goodness of fit were used. The results reported were .051 (Root Mean Squared Error of Approximation), .061 (Root Mean Squared Residual) and .80 (Adjusted Goodness-of-Fit Index). Concurrent validity was found by correlating the SPSI-R with another popular problem-solving instrument, Problem-Solving Inventory (PSI; Heppner, 1988 as cited in D'Zurilla, Nezu, & Maydeu-Olivares, 2002). The correlations were moderate, ranging from -.33 to .75. Studies focusing on predictive validity found that all of the SPSI-R scales, except RPS were significantly correlated with different distress measures (i.e., Symptom Checklist 90 – Revised; Beck Depression Inventory; Suicide Probability Scale) in the expected direction. Some of the significant correlations were .17 (Suicidality), .68 (Anxiety) and -.36 (Hopelessness). One study examining convergent validity used the Internal-External Locus of Control Scale (I-E). It was found that correlations between the PPO, NPO and AS scales and the I-E were significant and modest, r = -.25, .30, and .23 ($p < .01$). Finally, discriminant validity was measured using academic aptitude. Results indicate that none of the SPSI-R scales were significantly related to verbal SAT scores (D'Zurilla and Chang, 1995).

The Participant Information Questionnaire is a brief, two-page, self-administered questionnaire developed by the author to assess patient demographics and other information deemed important to this research. The questionnaire is similar to those commonly used during an intake procedure and covers such areas as prescription medication currently used, hospitalisations, marital status and level of educational attainment. The questionnaire consists of fill in the blank, multiple choice and yes/no responses.

Procedure

This project involved the use of two different samples, BPD group and a control group. A slightly different procedure was used for each sample. The procedure for each sample is described below.

First, the BPD group was contacted approximately one to two weeks before the expected data collection date and given an Information Letter, which explained the purpose and time commitment of the study, risks and benefits and participant rights. For those women who chose to participate they were given a package containing the instruments utilized for this group. The instruments for this study included a Consent Form, ISS, ISEL-12, SPSI-R and the Participant Information Questionnaire. All women had previously been given the DIB-R by their psychiatrist upon admission to the aftercare program and had obtained a score of 8 or higher on the instrument. All the participants in the BPD group were tested within the same week at the hospital.

Second, the control group consisted of students from two university undergraduate classes. During a designated class time, the researcher handed out the Information Letter and reviewed it with the class. Those students who chose to participate were given a package containing the following instruments: a Consent Form, ISS, ISEL-12, SPSI-R, the Participant Information Questionnaire and the Cluster B Personality Scales of the PDQ-4. Both of the undergraduate classes were tested within the same week and in the same building at the University.

All of the participants were treated in a manner consistent with the ethical guidelines set out by both the University of Alberta and the Capital Health Authority. Ethics approval from the University of Alberta Faculties of Education and Extension

Research Ethics Board and the University of Alberta Health Sciences Faculties, Capital Health Authority and Caritas Health Group Research Ethics Board (Panel B) was obtained.

Results

Hypothesis One

Social problem-solving skill was assessed using the SPSI-R (D'Zurilla, et al., 2002). The overall level of social problem-solving was used (total score). A higher score indicated "more effective problem solving, whereas lower scores indicate more defective or dysfunctional problem-solving" (D'Zurilla, et al., 2002).

The mean total SPSI-R score for the BPD group was 83.03 (*SD* = 16.28) and 106.61 (*SD* = 11.53) for the control group. An independent t-test with an alpha level of .01 was used for the t-test. The BPD group scored significantly lower than the control group, t (83) = 7.82, $p < .01$. Hypothesis one was supported – the control group has more effective social problem-solving skills than the BPD group.

Hypothesis Two

This hypothesis was tested using the ISS and the SPSI-R. A Pearson correlation was used with an alpha level of .01. In both groups, there was a strong negative relationship between internalized shame and overall level of effective social problem-solving. The relationship was slightly stronger for the BPD group (r (36) = -.632, $p < .01$) than the control group (r (49) = -.611, $p < .01$).

Additional Pearson correlations were also conducted to determine the relationship between internalized shame and the different categories, or styles, of social problem-solving. Table 4-1 lists each of these correlations. Internalized shame was found to be significantly negatively correlated with the effective social problem-solving orientation of PPO for both groups. However, internalized shame was significantly negatively correlated with Rational Problem-Solving (RPS) for the control group but not the BPD group.

Table 4-1

Correlations between Internalized Shame and Social Problem-Solving Styles

Social Problem-Solving	BPD Group Internalized Shame	Control Group Internalized Shame
Overall Score	-.632*	-.611*
Positive Problem Orientation	-.366**	-.471*
Negative Problem Orientation	.547*	.701*
Rational Problem Solving	-.233	-.357**
Impulsive/Careless Style	.421**	.218
Avoidant Style	.503*	.428*

* $p < .05$ level (2-tailed).** $p < .01$ level (2-tailed).

Significant positive correlations were found for both groups when the relationship between internalized shame and the ineffective social problem-solving orientation of NPO and Avoidant Style (AS) were examined. The Impulsive/

Careless Style (ICS) was significantly correlated with internalized shame for the BPD group but not the control group. Overall, hypothesis two is supported. There was a negative relationship between internalized shame and social problem-solving.

Hypothesis Three

This hypothesis was tested using the SPSI-R. Simple descriptive statistics, mean, median and SD, as well as a t-test were used to determine whether the social problem-solving style of Avoidance was highest for the BPD group.

First, when considering overall problem orientation the BPD group scored significantly higher on the Negative Problem Orientation (*M* = 123.08, *SD* = 19.61) than the Positive Problem Orientation scale (*M* = 86.14, *SD* = 16.78) as demonstrated using a paired sample t-test (t (35) = -7.63 p < .01).

Similarly, the two scales measuring styles of NPO (Avoidance and Impulsive/Careless) were higher than the scale measuring a style of PPO (Rational Problem Solving). The descriptive statistics for the three styles, from highest to lowest means, are: AS (*M* = 111.78, *SD* = 15.61), ICS (*M* = 107.58, *SD* = 17.82) and RPS (*M* = 89.83, *SD* = 16.21). Overall, hypothesis three is supported – the BPD group scored the highest on the avoidance style of social problem-solving

Hypothesis Four

This hypothesis was tested using the ISEL-12. The ISEL-12 is composed of four different scales. The Total Score is the overall level of reported social support. The Total Score is the sum of the three subscales: Appraisal (having someone to talk to), Belonging (having someone to do things with) and Tangible (the ability to obtain material aid). The Total Score can range from 0-48, while each subscale ranges in score from 0-16. Descriptive statistics and t-scores are presented in Table 4-2. The control group scored significantly higher on all measures of social support at the alpha level of .01. Overall, hypothesis four is supported – the control group reported more social support than the BPD group.

Table 4-2

A Comparison of the BPD and Control Group Scores on Measures of Social Support

	BPD Group		Control Group		t-test
Measure	*M*	*SD*	*M*	*SD*	*t**
Total Support	32.28	8.21	42.51	4.12	7.54
Appraisal	11.36	3.20	14.88	1.45	6.81
Belonging	9.50	2.78	13.67	1.90	8.22
Tangible	11.42	3.07	13.94	1.76	4.78

Note. Scores range from 0-48 for the Total Support Scale and from 0-16 for each of the other scales.
$^*p < .01$.

Research Question

Do any of the variables (internalized shame, social support and/or social problem-solving) effectively differentiate between the control group and the BPD group?

This question was tested using the ISS (internalized shame), ISEL-12 (social support) and SPSI-R (social problem-solving). To test whether any of the variables were able to discriminate between members of the BPD and control groups, a discriminant function analysis (DFA) was used. First, a MANOVA was conducted to see if the multivariate test was significant. The results indicated that Box's test was significant ($p < .01$) as was Levene's test of equality for two of the variables. The results of Levene's test were as follows: ISS, $F = .64$, $p = .43$; SPSI-R, $F = 5.96$, $p = .02$; and ISEL-12, $F = 20.52$, $p < .01$. Therefore, the assumptions were not met. Since a MANOVA is robust to the assumptions of equal covariances if the groups are equal in number, a random sample of 36 cases from the control group's original 49 were selected. This made each group equal with a total n = 72. A second MANOVA was conducted and the multivariate omnibus test was significant so it was concluded that there were main effects for all three variables. Next, a DFA was conducted.

To compare the relative importance of each variable in the DFA, an interpretation of the standardized coefficients was done. The results indicated that ISS has the greatest impact as it contributes the most to the overall discrimination. The standardized coefficients were: ISS = .870, SPSI-R = -.136 and ISEL-12 = -.063. Similarly, the structure matrix indicated that ISS has the largest correlation with the canonical variable scores and was the most strongly represented variable. There was a strong positive relationship between the canonical variable and ISS ($r = .992$) and a moderate negative relationship between SPSI-R ($r = -.692$) and ISEL-12 ($r = -.679$) and the canonical variable.

Overall, the results indicated that the three variables, internalized shame, social support and social problem-solving ability could each be used to differentiate between women belonging to the BPD and control group. Of each of the variables, internalized shame was found to be the variable with the most strength to differentiate.

Discussion

Social problem-solving is characterized as an ability that "contributes to social competence and overall well being, as the ability to cope with and resolve everyday stressful problems and is strongly related to personal and social functioning" (D'Zurilla, et al., 2002, p. 3). This study found that women with BPD have significantly less effective social problem-solving when compared to women in a control group. Examination of the social problem-solving skills reported by the women revealed that the BPD women had a negative problem orientation. This orientation is characterized by experiencing negative emotions (e.g., helplessness, anxiety) when faced with problems and an inability to generate effective solutions.

A closer investigation of one of the variables hypothesized to impede social problem-solving, internalized shame, revealed an interesting relationship. Those who reported the greatest level of internalized shame also reported the least effective social problem-solving skills. This negative relationship was consistent with previous research and anecdotal reports purporting that internalized shame hampers positive problem-solving (e.g., Cook, 2001; Linehan, 1993; Nathanson, 1996). Specifically, the behavioural reaction to internalized shame (i.e., avoidance, withdrawal) clashes with what is required to solve problems effectively.

The overt behaviour utilized by an individual is referred to as their problem-solving style (D'Zurilla, et al., 2002). This study revealed that women diagnosed with BPD are much more likely to report using dysfunctional social problem-solving styles than effective styles. The most commonly reported style was that of Avoidance. This style is characterized by "procrastination, passivity or inaction, and dependency. An individual . . . puts off solving problems for as long as possible, waits for problems to resolve themselves, and attempts to shift the responsibility for solving his or her problems to others" (D'Zurilla, et al., 2002, p.5). The reaction to internalized shame is often avoidance, which consists of behaviours that distract from feeling the shame (Cook, 2001) in hopes the feeling will go away on its own.

The finding that Avoidance is a commonly used approach supports researchers who found that BPD women have overall poor problem-solving, feel threatened by problems, act in ways to avoid the problem and try to elicit others to solve the problems for them (Douglass, 2000; Linehan, 1993). The lack of social problem-solving impedes the BPD's ability to handle minor difficulties and interpersonal problems. Ironically, the reaction of the borderline to problems acts in such a way as to repel others away from them – the very thing they desperately do not want to do. It is likely that this behaviour reinforces the BPD frantic efforts to avoid abandonment and is apparent in their history of unstable and intense relationships (APA, 2000). This is unfortunate since it has been observed that the BPD often respond well to positive relationships (Linehan, 1993). However, the BPD's negative behaviours (e.g., emotional reactivity, reaction to internalized shame) coupled with dysfunctional social problem-solving, sabotages these relationships.

To better understand the social support available to the BPD women, this study examined the woman's perceived availability of social resources. Compared to the control group, the BPD women reported significantly less social support. In particular, they reported very low levels of "belonging". Belonging refers to the perceived availability of having someone to do things with (Cohen, Mermelstein, Kamarck, &

Hoberman, 1985). For example, having a friend to go see a movie with or being invited to join in activities with others. A possible connection to the commonly reported feelings of loneliness and isolation reported within this population may also be explained by their living arrangements. In this study, 19.4% of the BPD women reported living alone compared to only 4.1% of the control group. The combined effects of low social problem-solving and high internalized shame may disrupt the borderline personality disordered individual's ability to sustain healthy relationships. It appears to be a vicious circle for the individual. It has been hypothesized that when people feel shame they fear abandonment (Middleton-Moz, 1990), especially if the reason for the shame is discussed. With the BPD woman's lack of social problem-solving skills she is unable to apply the solutions necessary to solve this problem and relies on her dysfunctional style of avoiding the problems. This, in turn, has a negative effect on other people and they are pushed away by her behaviours. The result is that the BPD woman becomes more shamed and desperate for a relationship.

It is often reported that the BPD have a myriad of puzzling, hard to change behaviours that makes treatment difficult. Mental health workers often do not know where to start with the individual diagnosed with BPD. To try to address this dilemma, this study attempted to determine which variable was most effective in discriminating between the control group and the BPD group. The variables used were social problem-solving, internalized shame and reported level of social support. Using a discriminant function framework to predict group membership (i.e., separation of the two groups) indicated that internalized shame accounted for a significant proportion of the variance. In other words, knowing an individual's level of internalized shame enabled a fairly accurate prediction of what group she belonged in. The higher the level of internalized shame reported, the more likely the woman had the diagnosis of BPD. While it may be premature to agree with Langley's (1993) assertion that shame is the core emotion experienced by those with BPD, this research does lend support to the notion that internalized shame is a particularly important emotion to consider.

Conclusion and Future Directions

The purpose of this study was to clarify and identify the impact of internalized shame and examine other possible factors that interfere with the BPD woman's ability to acquire and sustain positive social networks. The woman's reported degree of internalized shame and her social problem-solving abilities were found to play a significant role in her level of social support. Overall, the BPD women were found to engage in a negative social problem-solving style of Avoidance and to have high levels of internalized shame. It was argued that these two destructive features found in the sample had a strong negative effect on the woman's availability of a satisfying social network, whether it is the accessibility of material aid or a sense of having friends and belonging to a group.

Of the themes addressed in this study, both the BPD woman's level of internalized shame and social problem-solving ability appear to have important implications for the mental health worker involved in treating those with BPD. The results of this study offer two pragmatic and research suggestions. The first important finding is that internalized shame is a prominent emotion reported in this population. Shame is believed to have a negative impact on both the woman's quality of life and have detrimental effects on treatment (Linehan, 1993). This is especially likely if the presentation of internalized shame is not recognized and addressed by the therapist or mental health worker. It may also be that many of the damaging behaviours engaged in by the borderline (e.g., self mutilation, angry outbursts) may be brought on by shameful feelings. Focusing on reducing the shame level in these women may have the desired affect of also reducing some of the common maladaptive behaviours seen in this population. This hypothesis would be an interesting topic for future research and may be of significant value to those engaged in a therapeutic relationship with those diagnosed with BPD.

The second suggestion rests on the finding that the person with BPD tends to respond to both everyday difficulties and interpersonal problems using avoidance. An exploration of what treatment method is most effective in changing this dysfunctional approach seems warranted. For example, it is Linehan's (1993) goal, using DBT, to train the individuals in problem-solving and enable them to build social and personal skills to deal effectively with problems in their life. Does DBT work to improve the BPD's social problem-solving skills? Do other treatment methods work better? The understanding of treatment effectiveness in the ability to offer the borderline a more positive approach to solving problems would be a goal of research that followed this theme.

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CHAPTER 5

SUMMARY

Summary of Research Findings

The research conducted for this dissertation represents a program of research investigating the significant emotional and behavioural difficulties experienced by women diagnosed with BPD. A focus on the impact of internalized shame was intended to add a new dimension to the understanding of the complex symptoms displayed by this population. Three separate, but conceptually related empirical studies, were undertaken to clarify the role of internalized shame in women diagnosed with BPD by both comparing their results to a control group of university women and by examining the nuances within the BPD group itself.

The impact of internalized shame was first investigated to determine whether there was a significant relationship with psychiatric symptomatology. The use of an instrument measuring psychiatric symptomatology gave both an overall level of functioning and separate mental health domains such as depression, hostility and anxiety. Comparisons with the control group demonstrated that BPD women reported significantly more symptoms and higher internalized shame. More importantly, a strong relationship between internalized shame and psychiatric symptomatology was established. Those who reported the highest levels of psychopathology also reported the most internalized shame. Results from this study suggest that internalized shame is an important emotion experienced by the BPD women and may exacerbate the presentation of other negative emotions and behaviours.

To complement this study and provide further understanding of the impact of internalized shame, a second investigation was conducted to explore the commonly reported experience of trauma and its relationship with internalized shame and psychiatric symptomatology. The literature is divided on whether the type of trauma experienced can account for differences in the BPD women's ability to function effectively. Specifically, there is disagreement on whether sexual abuse has an overall more devastating effect on the woman than other types of trauma such as death of a family member or a serious car accident. The findings from this research suggest that the type of trauma did *not* predict which women would report the highest levels of internalized shame and/or psychiatric symptomatology. It appears that the combination of the traumatic event and the woman's response to the trauma, namely their experience of shameful feelings, interact and negatively impact their experience of psychiatric symptoms.

A third study was conducted to provide further clarification on the impact of internalized shame as well as to offer possible reasons for the often reported difficulty in the effective treatment of BPD. As such, the focus was on the women's capability to solve their own social problems and their ability to obtain and sustain positive relationships. Effective social problem-solving refers to the ability to solve everyday dilemmas in a consistent, rational and confident manner. Results indicated that internalized shame acted as an obstacle to social problem-solving and those who reported high shame also tended to use the avoidance style of problem-solving.

The inability to become engaged in solving their own life problems and the use of avoidance and ignoring of problems may also impede their ability to maintain a strong social network. Indeed, the BPD group reported significantly less interpersonal success than the control group. The lack of effective social problem-solving coupled with high internalized shame appeared to be particularly detrimental to the borderlines reported level of social support.

Limitations

The influence and interaction of two factors may limit the interpretations and conclusions of this study: the limitations of the trauma data and the demographic homogeneity of the participants.

There are two limitations noted with the data collected on the reported traumas experienced by the participants in this study. First, because of the small number of women in the control group reporting sexual abuse ($n = 5$) a comparison between the this group and the BPD group was not possible. Thus, understanding whether the groups differed in their emotional reaction to various traumas was not completed. This limitation may have been circumvented by the use of a larger sample size. Second, the number of women with BPD reporting sexual abuse was much lower than reported in the literature. In this study, 38.9% of the women reported sexual abuse compared with 60-80% reported in other studies (e.g., Kroll, 1993). This difference may reflect the varying criteria used to define sexual abuse in the literature. For instance, some researchers consider inappropriate sexual touching to fall within the definition of sexual abuse. It is possible that the women in this study had a more narrow view of what constitutes sexual abuse (i.e., only vaginal penetration). Similarly, the measure used in this study asked for the type of trauma that was most upsetting to the women. It may be that the women experienced such things as inappropriate sexual touching but did not consider this to be a traumatic event. A more specific definition of the term sexual abuse would reduce this uncertainty.

The other limitation to the study is the relative homogeneity of the sample. The majority of the participants were Caucasian (91.7 % of the BPD group and 89.8% of the control group) and all were women. Thus, caution may be required when generalizing the results of this study to different cultural/ethnic groups or to groups that include men.

Contributions of the Research

Collectively, the three papers that comprise this dissertation make an original contribution to the field in a number of ways. The critical examination of the emotion of internalized shame offered empirical support to theory. While the importance of the role of shame has been suggested in the literature (APA, 2000; Cook, 2001; Langley, 1993; Rizvi & Linehan, 2002) this study focused on the effects of this emotion on the BPD and isolated several important findings. First, it was discovered that 80% of women with BPD report frequent or high levels of internalized shame. This was significantly different from a control group of women and, in fact, the variable of internalized shame was found to discriminate effectively between the two groups. In other words, knowing the shame level of a woman enables you to better predict whether the woman has the diagnosis of BPD or not.

Another finding addressed the disagreement in the literature on whether sexual abuse is a traumatic event that affects the BPD more intensely than other types of traumas (e.g., serious car accident). Some researchers have suggested that there needs to be a new category, termed the PTSD/Borderline to capture the unique attributes of BPD women who were sexually abused (Kroll, 1993). This research did not support this assertion. Interestingly, the results support the idea that it may be the woman's response to the trauma, rather than the specific type of event, especially their reported feelings of shame. Indeed, it appears that high internalized shame and a history of trauma (regardless of type) combine to exacerbate and maintain the BPD's symptoms.

The third unique finding of this research was found when examining the BPD ability to social problem-solve. Understanding the dysfunctional responses to everyday problems and interpersonal disputes resulted in the finding that the borderlines use an avoidance style of social problem-solving. This style is characterized by "procrastination, passivity or inaction, and dependency" (D'Zurilla, et al., 2002, p.5). Interestingly, the reaction to internalized shame is often avoidance, which consists of behaviours that distract from feeling the shame (Cook, 2001) in hopes the emotion will resolve itself. Knowing the BPD response is important for those involved in developing a treatment plan for women with this diagnosis.

The studies in this paper also lend support to other research in the field. For example, research focusing on social support and the high level of psychiatric symptomatology commonly reported in this population. When examining social support, this investigation revealed BPDs report a lack of social network, especially in reported feelings of belongingness. The chaotic and unstable relationships engaged in by BPD women and the corresponding feelings of loneliness and abandonment are well documented in the literature (APA, 2000; Linehan, 1993). This study also supports the claim that there is a positive relationship between internalized shame and psychiatric symptomatology (e.g., interpersonal sensitivity, psychoticism) (Balcom, Call & Pearlman, 2000; Cook 2001; Lewis, 1992).

Future Directions and Conclusion

There are potentially many directions in which to continue this program of research. However, after examining the results of the research presented here, two main themes for future research emerged. First, the relationship between anger and internalized shame needs to be better understood. It is unclear whether these two emotions are distinct and independent or if they occur together and intensify one another. For example, is anger a response to, or defence against, feelings of internalized shame? Second, an examination of the effectiveness of different treatment methods would offer practical implications. A study utilizing a pre-post design measuring the effects of treatment on problem-solving ability and reported levels of shame, trauma and psychiatric symptomatology would be useful for the mental health professional.

Overall, this study offered a unique look at the role of internalized shame in the functioning of women with BPD. The findings of these investigations support the assertion that high levels of internalized shame have a negative impact on various aspects of the borderline's life, from their current reports of traumatic feelings to perceived level of social support. The focus of future research may best serve this population by focusing on internalized shame and treatment effectiveness in hopes to understand and treat the challenging and complex behaviours found within the BPD group.

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Appendix A

DSM-IV-TR Criteria

Borderline Personality Disorder (301.83)

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) frantic efforts to avoid real or imagined abandonment.
Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5

(2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

(3) identity disturbance: markedly and persistently unstable self-image or sense of self

(4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, Substance Abuse, reckless driving, binge eating)
Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5

(5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

(6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)

(7) chronic feelings of emptiness

(8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)

(9) transient, stress-related paranoid ideation or severe dissociative symptoms

Appendix B

Linehan's Reorganization of the DSM-IV Criteria for BPD

Criteria for Borderline Personality Disorder
Emotional Dysregulation
Emotional instability
Problems with anger
Interpersonal Dysregulation
Unstable relationships
Efforts to avoid loss
Behavioural Dysregulation
Suicide threats, parasuicide
Self-damaging, impulsive behaviours, including alcohol and drug abuse
Cognitive Dysregulation
Cognitive disturbances
Self Dysfunction
Unstable self, self-image
Chronic emptiness

Note. This table was adapted from Linehan, 1993 (p. 13)

Appendix C

Information Letter for the University (Control) Sample

UNIVERSITY OF ALBERTA
INFORMATION LETTER

Research Project Title: A Study of the Relationship Between Emotions, Behaviour and Specific Life Events in Adult Women.
Researcher: Melanie Chan, PhD (Candidate)

Thank-you for your interest in participating in this research project. The information gathered in this project will be used in partial fulfillment of the degree requirement for the Doctor of Philosophy program in the department of Educational Psychology.

This information letter is part of the process of informed consent. It will give you the basic idea of what the research is about and what your participation will involve, if you choose to participate. If you would like more detail about something mentioned here, or information not included here, please email Melanie at machan@ualberta.ca.

The purpose of this research study is to examine some factors that may influence the emotions and behaviours that some people report feeling or doing. Specifically, this study will look at whether a difficult situation in your past influences how you feel and how you behave today. The study will also look at the role that social support (i.e., friends) plays in your life.

The study will require between 45 to 60 minutes of your time. During this time, you will be asked to complete 6 paper and pencil questionnaires. Your responses, along with those of approximately 99 other adult women will be used to form the data in this study.

Thinking about a past difficult event may trigger some strong feelings for you. If you feel that you do not want to continue in the research, please feel free to decline participation at any point. It is your decision if you wish to withdraw and I encourage you to do so if you feel it will be too upsetting. If you opt out of the research it will be without penalty and any collected data will not be included in the study. Please note that after all the questionnaires have been handed in, the researcher, Melanie Chan, as well as your doctor, will be available to answer any questions you may have and/or address any concerns.

All of the information I collect from you (your questionnaire answers) will be stored so that your name is not associated with it. The write-up of the data will not include any information that can be linked directly to you, to ensure your confidentiality. All information will be held confidential (or private), except when professional codes of ethics or legislation (or the law) require reporting. The information you provide will be kept for at least five years after the study is done. The information will be kept in a secure area (i.e., locked filing cabinet). Your name or any other identifying information will not be attached to the information you gave. Your name will also never be used in any presentations or publications of the study results. The information gathered for this study may be looked at again in the future to help us answer other study questions. If so, the ethics board will first review the study to ensure the information is used ethically. Five years after the study is completed, all the research instruments (i.e., questionnaires) will be shredded.

If you have further questions concerning this research, please contact:
Researcher: Melanie Chan: PhD Student, University of Alberta.
Email Address: machan@ualberta.ca
Research Supervisor: Dr. Gretchen Hess, Vice Provost, University of Alberta.
Phone Number: (780) 492-2280
Department of Educational Psychology Chair: Dr. Linda McDonald, University of Alberta
Email Address: linda.mcdonald@ualberta.ca
Phone Number: (780) 492-2389

This study has been reviewed and approved by the Research Ethics Board of the Faculties of Education and Extension at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Chair of the Research Ethics Board at (780) 492-3751.

A copy of this information letter has been given to you to keep for your records and reference.

Appendix D

Information Letter for the Hospital (Clinical) Sample

UNIVERSITY OF ALBERTA
INFORMATION LETTER

Research Project Title: A Study of the Relationship Between Emotions, Behaviour and Specific Life Events in Adult Women.
Researcher: Melanie Chan, PhD (Candidate)

Introduction:

Thank-you for your interest in participating in this research project. The information gathered in this project will be used in partial fulfillment of the degree requirement for the Doctor of Philosophy program in the department of Educational Psychology.

This information letter is part of the process of informed consent. It will give you the basic idea of what the research is about and what your participation will involve, if you choose to participate. If you would like more detail about something mentioned here, or other information about this research project please email Melanie Chan at machan@ualberta.ca.

Purpose of Research and Participant Involvement:

The purpose of this research study is to examine how emotions, behaviour and life events are related. For example, you will be asked how you would rate your mood or feelings, whether you feel happy, sad or angry at certain times. You will also be asked questions about the role that family and friends play in your life. Further, there will be questions focusing on whether a difficult situation in your past influences how you feel and how you behave today. This study will also ask some general questions about your background such as age and education.

The study will require between 45 to 60 minutes of your time. During this time, you will be asked to complete 7 paper and pencil questionnaires. Your responses, along with those of approximately 90-100 other adult women will be used to form the data in this study.

Benefits/Risks of the Research:

Thinking about a past difficult event or negative emotions may trigger some strong feelings for you. If you feel that you do not want to continue in the research, please feel free to decline participation at any point. It is your decision if you wish to withdraw and I encourage you to do so if you feel it will be too upsetting. If you opt out of the research it will be without penalty and this decision will not affect your care in any way. If you choose to participate, you have the right to choose to skip any question that you do not wish to answer. Please note that after all the questionnaires have been handed in, the researcher, Melanie Chan, as well as a member of your Mental Health Team, will be available to answer any questions you may have and/or address any concerns.

There are three potential benefits of this research. First, understanding the role that emotions play in the lives of women who are receiving treatment is important to the success of therapy and understanding what works and what does not work. Second, this study will enable the researcher to provide group information to the Mental Health Team. This information is valuable because it allows the Mental Health Team to gain a better understanding of the needs and strengths of the women they treat. Lastly, it is a goal of the researcher to report group findings in an academic journal and present the findings to colleagues through poster presentations at research conferences. This will allow for academic discussion and knowledge sharing.

Confidentiality:

All of the information I collect from you (your questionnaire answers) will be stored so that your name is not associated with it. The write-up of the data will not include any information that can be linked directly to you, to ensure your confidentiality. All information will be held confidential (or private) except when professional codes of ethics or legislation (or the law) require reporting. The information you provide will be kept for at least five years after the study is done. The information will be kept in a secure area (i.e., locked filing cabinet). Your name or any other identifying information will not be attached to the information you gave. Your name will also never be used in any presentations or publications of the study results. The information gathered for this study may be looked at again in the future to help us answer other study questions. If so, the ethics board will first review the study to ensure the information is used ethically. Five years after the study is completed, all the research instruments (i.e., questionnaires) will be shredded.

Results of the Research:

A brief, preliminary summary of the group results (the findings of the research project) will be available in approximately 6 months. If you would like a copy of the summary please email the researcher at machan@ualberta.ca. A copy of the summary will also be sent to the members of your Mental Health Team. If you prefer, you can ask them for a copy.

If you have further questions concerning this research, please contact:
Researcher: Melanie Chan: PhD Student, University of Alberta.
  Email Address: machan@ualberta.ca
Research Supervisor: Dr. Gretchen Hess, Vice Provost, University of Alberta.
  Phone Number: (780) 492-2280
Department of Educational Psychology Chair: Dr. Linda McDonald, University of Alberta
  Email Address: linda.mcdonald@ualberta.ca
  Phone Number: (780) 492-2389

This study has been reviewed and approved by the Research Ethics Board of the Faculties of Education and Extension and the Health Research Ethics Board (Panel B) at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Chair of the Research Ethics Board at (780) 492-3751.

A copy of this Information Letter has been given to you to keep for your records and reference.

Appendix E

Consent Form for the University (Control) and Hospital (Clinical) Samples

UNIVERSITY OF ALBERTA
CONSENT FORM

Part 1: Researcher Information

Research Project Title: A study of the relationships between emotions, behaviour and specific life events in adult women
Name of Principal Investigator: Melanie A. Chan
Affiliation: University of Alberta
Contact Information: machan@ualberta.ca

Name of Supervisor: Dr. Gretchen Hess
Affiliation: University of Alberta
Contact Information: (780) 492-2280

Part 2: Consent of Participant

	Yes	**No**
Do you understand that you have been asked to be in a research study?		
Have you read and received a copy of the attached Information Letter?		
Do you understand the benefits and risks involved in taking part in this research study?		
Have you had an opportunity to ask questions and discuss the study?		
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and there will be no negative consequences.		
Has the issue of confidentiality been explained to you? Do you understand who will have access to your information?		

Part 3: Signatures

This study was explained to me by: ______________________________
Date: ______________________________

I agree to take part in this study.

Signature of Research Participant: ______________________________
Printed Name: ______________________________

Witness (if available): ______________________________
Printed Name: ______________________________

I believe that the person signing this form understands what is involved and voluntarily agrees to participate.

Researcher: ______________________________
Printed Name: ______________________________

** A copy of this consent form has been given to you to keep for your records and reference.*

Appendix F

Overview of the Diagnostic Interview for Borderlines – Revised (DIB-R)

Zanarini, Gunderson, Franckenburg and Chauncey

Affect Section

1. Chronic/major depression
2. Chronic helplessness/hopelessness/worthlessness/guilt
3. Chronic anger/frequent angry acts
4. Chronic anxiety
5. Chronic loneliness/boredom/emptiness

Cognition Section

6. Odd thinking/unusual perceptual experiences
7. Nondelusional paranoid experiences
8. Quasi-psychotic experiences

Impulse Action Patterns Section

9. Substance abuse/dependence
10. Sexual deviance
11. Self-mutilation
12. Manipulative suicide efforts
13. Other impulsive patterns

Interpersonal Relationships Section

14. Intolerance of aloneness
15. Abandonment/engulfment/annihilation concerns
16. Counterdependency/serious conflict over help or care
17. Stormy relationships
18. Dependency/masochism
19. Devaluation/manipulation/sadism
20. Demandingness/entitlement
21. Treatment regressions
22. Countertranference problems/ "special" treatment relationships

Appendix G

Personality Diagnostic Questionnaire – 4 (Cluster B Items)

Steven E. Hyler

Instructions: The purpose of this questionnaire is for you to describe the kind of person you are. When answering the questions, think about how you have tended to feel, think and act ***over the past several years.*** Please answer either **T**rue or **F**alse to each item. Where T (True) means that the statement is generally true for you. F (False) means that the statement is generally false for you. There are no correct answers.

Over the past several years . . .

1. I need to be the centre of attention. T F
2. I have accomplished far more than others give me credit for. T F
3. I'll go to extremes to prevent those who I love from ever leaving me. T F
4. Sometimes I get upset. T F
5. I am "sexier" than most people. T F
6. I often find myself thinking about how great a person I am, or will be. T F
7. I either love someone or hate them, with nothing in between. T F
8. I get into a lot of physical fights. T F
9. Occasionally I talk about people behind their backs. T F
10. I show my emotions easily. T F
11. Only certain special people can really appreciate and understand me. T F
12. I often wonder who I really am. T F
13. I have difficulty paying bills because I don't stay at any one job for long. T F
14. There are some people I don't like. T F
15. I use my "looks" to get the attention that I need. T F
16. I very much need other people to take notice of me or compliment me. T F
17. I have tried to hurt or kill myself. T F
18. I do a lot of things without considering the consequences. T F
19. I have never told a lie. T F
20. Even though I talk a lot, people say that I have trouble getting to the point. T F
22. I expect other people to do favours for me even though I do not usually do favours for them. T F
23. I am a very moody person. T F
24. Lying comes easily to me and I often do it. T F
25. A nuclear war may not be such a bad idea. T F
26. I have a flair for the dramatic. T F
27. Some people think that I take advantage of others. T F
28. I feel that my life is dull and meaningless. T F

Over the past several years . . .

29. People have often complained that I did not realize that they were upset. T F

30. I enjoy doing risky things. T F

31. I have lied a lot on this questionnaire. T F

32. I have difficulty controlling my anger or temper. T F

33. Some people are jealous of me. T F

34. I am easily influenced by others. T F

35. I take relationships more seriously than do those who I'm involved with. T F

36. Others consider me to be stuck up. T F

37. When stressed, things happen. Like I get paranoid or just "black out". T F

38. I don't care if others get hurt so long as I get what I want. T F

39. I have done things on impulse (such as those below ↓) that could have gotten me into trouble. T F

If you answered true to question 39, please check all that apply to you:

a. Spending more money than I have ☐
b. Having sex with people I hardly know ☐
c. Drinking too much ☐
d. Taking drugs ☐
e. Eating binges ☐
f. Reckless driving ☐

40. When I was a kid (before age 15), I was somewhat of a juvenile delinquent, doing some of the things below. T F

Now, please check all that apply to you:

a. I was considered a bully ☐
b. I used to start fights with other kids ☐
c. I used a weapon in fights that I had ☐
d. I robbed or mugged other people ☐
e. I was physically cruel to other people ☐
f. I was physically cruel to animals ☐
g. I lied a lot ☐
h. I stayed out at night without my parents' permission ☐
i. I stole things from others ☐
j. I set fires ☐
k. I broke windows or destroyed property ☐
l. I ran away from home overnight more than once ☐
m. I began skipping school a lot, before age 13 ☐
n. I broke into someone's house, building or car ☐

Please answer these last 5 questions about the items you marked "true" in this questionnaire:

A. Read the items that you have checked as "true", are they really true of you?
Yes **No**

B. Have these items been a part of your personality for at least the last several years?
Yes **No**

C. Have these items been part of your personality most of the time regardless of your mood, use of alcohol/drugs or general state of health? **Yes** **No**

D. Are you *bothered* about yourself because of these behaviours? **Yes** **No**

E. In what areas have these items created difficulties for you (please circle all that apply to you):

Home? **Work?** **Relationships?** **Other areas of your life?**

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Appendix H

Sample Questions from the Symptom Assessment – 45 Questionnaire
Strategic Advantages, Inc.

1 = Not at all   2 = A little bit   3 = Moderately   4 = Quite a bit   5 = Extremely

1. Feeling no interest in things	1	2	3	4	5
2. Feeling others are to blame for most of your troubles	1	2	3	4	5
3. Suddenly scared for no reason	1	2	3	4	5
4. Feeling others do not understand you or are unsympathetic	1	2	3	4	5
5. Feeling inferior to others	1	2	3	4	5

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Appendix I

Sample Questions from the Internalized Shame Scale
David R. Cook

0 = Never 1 = Seldom 2 = Sometimes 3 = Often 4 = Almost Always

1. I think that people look down on me 0 1 2 3 4
2. I feel insecure about others' opinions of me 0 1 2 3 4
3. I feel intensely inadequate and full of self doubt 0 1 2 3 4
4. I feel I have a number of good qualities 0 1 2 3 4
5. Sometimes I feel no bigger than a pea 0 1 2 3 4

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Appendix J

Participant Information Questionnaire
Melanie Chan

1. Age: ________________________ 2. Gender: _______________

3. Ethnicity (Please Circle):

Asian Black Caucasian East Indian First Nations Other (Specify): ________

4. What is the highest grade/level of education that you have completed (Please Circle)?

a) Less than grade 6
b) Junior high school (grade 7, 8 or 9)
c) Some high school (grade 10, 11 or 12)
d) High school diploma
e) Certificate/Diploma program
f) Some University/College
g) College/University degree
h) Graduate/Professional degree

5. Are you currently employed? Yes No

5A. If yes – How many hours a week do you work? ___________________

6. What is the approximate annual income of your household?

a) Less than $10,000
b) $10,000 - $20,000
c) $20,000 - $30,000
d) $30,000 - $40,000
e) $40,000 - $50,000
f) $50,000 or more

7. What is your current relationship status (Please Circle)?

Single Married/Common-Law Divorced/Separated Widowed

8. Do you live alone? Yes No

8A. If No – Who are you currently living with (please include any pets)? __________

9. Please describe any previous hospitalisations (i.e., length of stay, reason). __________

10. Are you currently taking any prescription medications? Yes No

10A. If yes – please list the medications you are taking. ______________________________

____

____

____

11. Do you drink alcohol? Yes No

11A. If yes – How many times do you drink alcohol in an average week (Please Circle)?

a) Less than once a week	c) Two or three times a week
b) About once a week	d) More than three times a week

11B. On average, how much do you drink at one time? (Please Circle).

a) One drink or less	c) Two drinks
b) Three drinks	d) More than three drinks

12. Do you smoke cigarettes? Yes No

12A. If yes – How many cigarettes do you usually smoke in an average week (Please Circle)?

a) Less than 5 cigarettes a day	c) ½ a pack to 1 pack a day
b) 5 cigarettes to ½ a pack a day	d) more than 1 pack a day

13. Do you currently take any non-prescription (i.e., illegal) drugs? Yes No

13A. If yes – Please list the drugs you have taken in the last one month. ____________________

____

____

____

Appendix K

Sample Questions from the Davidson Trauma Scale
Jonathan R. T. Davidson, M.D.

Please identify the trauma that is most disturbing to you. ______________________________.

1. Have you felt as though the event was recurring? Was it as if you were reliving it?
2. Have you been avoiding any thoughts or feelings about the event?
3. Have you felt distant or cut off from other people?
4. Have you been irritable or had outbursts of anger?
5. Have you been jumpy or easily startled?

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Appendix L

Interpersonal Support Evaluation List – 12
Dr. Sheldon Cohen

Instructions: This scale is made up of a list of statements each of which may or may not be true about you. For each statement circle "definitely true" if you are sure it is true about you and "probably true" if you think it is true but are not absolutely certain. Similarly, you should circle "definitely false" if you are sure the statement is false and "probably false" if you think it is false but are not absolutely certain.

1. If I wanted to go on a trip for a day (for example, to the country or mountains), I would have a hard time finding someone to go with me.

1. definitely false 2. probably false 3. probably true 4. definitely true

2. I feel that there is no one I can share my most private worries and fears with.

1. definitely false 2. probably false 3. probably true 4. definitely true

3. If I were sick, I could easily find someone to help me with my daily chores.

1. definitely false 2. probably false 3. probably true 4. definitely true

4. There is someone I can turn to for advice about handling problems with my family.

1. definitely false 2. probably false 3. probably true 4. definitely true

5. If I decide one afternoon that I would like to go to a movie that evening, I could easily find someone to go with me.

1. definitely false 2. probably false 3. probably true 4. definitely true

6. When I need suggestions on how to deal with a personal problem, I know someone I can turn to.

1. definitely false 2. probably false 3. probably true 4. definitely true

7. I don't often get invited to do things with others.

1. definitely false 2. probably false 3. probably true 4. definitely true

8. If I had to go out of town for a few weeks, it would be difficult to find someone who would look after my house or apartment (the plants, pets, garden, etc.).

1. definitely false 2. probably false 3. probably true 4. definitely true

9. If I wanted to have lunch with someone, I could easily find someone to join me.

1. definitely false 2. probably false 3. probably true 4. definitely true

10. If I was stranded 10 miles from home, there is someone I could call who could come and get me.

1. definitely false 2. probably false 3. probably true 4. definitely true

11. If a family crisis arose, it would be difficult to find someone who could give me good advice about how to handle it.

1. definitely false 2. probably false 3. probably true 4. definitely true

12. If I needed some help in moving to a new house or apartment, I would have a hard time finding someone to help me.

1. definitely false 2. probably false 3. probably true 4. definitely true

Appendix M

Sample Questions from the Social Problem-Solving Skills Inventory – Revised
Thomas J. D'Zurilla, Ph.D., Arthur M. Nezu, Ph. D., & Albert Maydeu-Olivares, Ph.D.

0 = Not at All True of Me　1 = Slightly True of Me　2 = Moderately True of Me
3 = Very True of Me　4 = Extremely True of Me

1. When making decisions, I do not fully evaluate all my options carefully enough
0 1 2 3 4

2. I feel nervous and unsure of myself when I have an important decision
0 1 2 3 4

3. I wait to see if a problem will resolve itself first, before trying to solve it myself
0 1 2 3 4

4. When a problem occurs in my life, I put off trying to solve it for as long as possible
0 1 2 3 4

5. Difficult problems make me very upset　0 1 2 3 4

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SENT VIA EMAIL

March 4, 2004

2707 1331 West Georgia Street
Vancouver, BC
V6E 4P1

Attention Melanie Chan:

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